State of Minnesota



# HOUSE OF REPRESENTATIVES

**NINETY-FIRST SESSION**

## H. F. No. 2414

03/13/2019 Authored by Liebling and Loeffler
The bill was read for the first time and referred to the Committee on Ways and Means
04/10/2019 Adoption of Report: Amended and re-referred to the Committee on Taxes
04/12/2019 Adoption of Report: Placed on the General Register
Read for the Second Time
04/24/2019 Calendar for the Day
Bill was laid on the Table

A bill for an act

relating to state government; establishing the health and human services budget; modifying provisions governing children and families, operations, direct care and treatment, continuing care for older adults, disability services, chemical and mental health, mental health uniform service standards, health care, prescription drugs, health-related licensing boards, Department of Health programs, health coverage, resident rights and consumer protections, independent senior living facilities, dementia care services for assisted living facilities with dementia care, assisted living licensure conforming changes, third-party logistics providers and wholesale distributors, and prescription drug pricing; establishing OneCare Buy-In; establishing pharmacy benefit manager licensure; establishing prescription drug repository program; establishing insulin assistance program; establishing OneCare Buy-In reserve account; establishing assisted living licensure; requiring reports; making technical changes; modifying penalties; providing for rulemaking; modifying fees; making forecast adjustments; appropriating money; amending Minnesota Statutes 2018, sections 8.31, subdivision 1; 13.46, subdivisions 2, 3; 13.461, subdivision 28; 13.69, subdivision 1; 13.851, by adding a subdivision; 15C.02; 16A.151, subdivision 2; 16A.724, subdivision 2; 18K.02, subdivision 3; 18K.03; 62A.021, by adding subdivisions; 62A.152, subdivision 3; 62A.25, subdivision 2; 62A.28, subdivision 2; 62A.30, by adding a subdivision; 62A.3094, subdivision 1; 62A.65, subdivision 7; 62A.671, subdivision 6; 62D.02, subdivision 4; 62D.03, subdivision 1; 62D.05, subdivision 1; 62D.06, subdivision 1; 62D.12, by adding a subdivision; 62D.124, subdivisions 1, 2, 3, by adding subdivisions; 62D.17, subdivision 1; 62D.19; 62D.30, subdivision 8; 62E.02, subdivision 3; 62E.23, subdivision 4; 62J.23, subdivision 2; 62J.497, subdivision 1; 62K.075; 62K.10, subdivisions 2, 3, 4, 5; 62Q.01, by adding a subdivision; 62Q.184, subdivisions 1, 3; 62Q.47; 62Q.81; 103I.005, subdivisions 2, 8a, 17a; 103I.205, subdivisions 1, 4, 9; 103I.208, subdivision 1; 103I.235, subdivision 3; 103I.301, subdivision 6, by adding a subdivision; 103I.601, subdivision 4; 119B.011, subdivisions 19, 20, by adding a subdivision; 119B.02, subdivisions 3, 6, 7; 119B.025, subdivision 1, by adding a subdivision; 119B.03, subdivision 9; 119B.05, subdivision 1; 119B.09, subdivisions 1, 7; 119B.095, subdivision 2, by adding a subdivision; 119B.125, subdivision 6; 119B.13, subdivisions 1, 6, 7; 119B.16, subdivisions 1, 1a, 1b, by adding subdivisions; 124D.142; 124D.165, subdivision 4; 125A.515, subdivisions 1, 3, 4, 5, 7, 8; 144.051, subdivisions 4, 5, 6; 144.057, subdivisions 1, 3; 144.0724, subdivisions 4, 5, 8; 144.121, subdivision 1a, by adding a subdivision; 144.122; 144.225, subdivisions 2, 2a, 7; 144.3831, subdivision 1; 144.412; 144.413, subdivisions 1, 4; 144.414, subdivisions 2, 3; 144.416;

144.4165; 144.4167, subdivision 4; 144.417, subdivision 4; 144.562, subdivision 2; 144.966, subdivision 2; 144.99, subdivision 1; 144A.04, subdivision 5; 144A.071, subdivisions 1a, 2, 3, 4a, 4c, 5a; 144A.073, subdivision 3c; 144A.20, subdivision 1; 144A.24; 144A.26; 144A.43, subdivisions 11, 30, by adding a subdivision; 144A.44, subdivision 1; 144A.471, subdivisions 7, 9; 144A.472, subdivisions 5, 7; 144A.473; 144A.474, subdivisions 2, 9, 11; 144A.475, subdivisions 1, 2, 3b, 5; 144A.476, subdivision 1; 144A.479, subdivision 7; 144A.4791, subdivisions 1, 3, 6, 7, 8, 9, 10; 144A.4792, subdivisions 1, 2, 5, 10; 144A.4793, subdivision 6; 144A.4796, subdivision 2; 144A.4797, subdivision 3; 144A.4798; 144A.4799; 144A.484, subdivision 1; 145.4235, subdivisions 2, 3, 4, by adding a subdivision; 147.37; 147D.27, by adding a subdivision; 147E.40, subdivision 1; 147F.17, subdivision 1; 148.59; 148.6445, subdivisions 1, 2, 2a, 3, 4, 5, 6, 10; 148.7815, subdivision 1; 148B.5301, subdivision 2; 148E.0555, subdivision 6; 148E.120, subdivision 2; 148E.180; 148F.11, subdivision 1; 150A.06, by adding subdivisions; 150A.091, by adding subdivisions; 151.01, subdivisions 23, 31, 35, by adding a subdivision; 151.06, by adding a subdivision; 151.065, subdivisions 1, 2, 3, 6; 151.071, subdivisions 1, 2; 151.15, subdivision 1, by adding subdivisions; 151.19, subdivisions 1, 3; 151.21, subdivision 7, by adding a subdivision; 151.211, subdivision 2, by adding a subdivision; 151.252, subdivisions 1, 1a, 3; 151.253, by adding a subdivision; 151.32; 151.40, subdivisions 1, 2; 151.43; 151.46; 151.47, subdivision 1, by adding a subdivision; 152.126, subdivision 6; 152.22, subdivisions 6, 11, 13, 14, by adding subdivisions; 152.25, subdivisions 1, 1a, 1c, 4; 152.27, subdivisions 2, 3, 4, 5, 6; 152.28, subdivision 1; 152.29, subdivisions 1, 2, 3; 152.31; 152.32, subdivision 2; 152.33, subdivisions 1, 2; 152.34; 152.36, subdivision 2; 171.171; 214.25, subdivision 2; 237.50, subdivisions 4a, 6a, 10a, 11, by adding subdivisions; 237.51, subdivisions 1, 5a; 237.52, subdivision 5; 237.53; 245.095; 245.462, subdivisions 6, 8, 9, 14, 17, 18, 21, 23, by adding a subdivision; 245.4661, subdivision 9; 245.467, subdivisions 2, 3; 245.469, subdivisions 1, 2; 245.470, subdivision 1; 245.4712, subdivision 2; 245.472, subdivision 2; 245.4863; 245.4871, subdivisions 9a, 10, 11a, 17, 21, 26, 27, 29, 32, 34; 245.4876, subdivisions 2, 3; 245.4879, subdivisions 1, 2; 245.488, subdivision 1; 245.4889, subdivision 1; 245.696, by adding a subdivision; 245.735, subdivision 3; 245A.02, subdivisions 3, 5a, 8, 9, 12, 14, 18, by adding subdivisions; 245A.03, subdivisions 1, 3; 245A.04, subdivisions 1, 2, 4, 6, 7, 10, by adding subdivisions; 245A.05; 245A.07, subdivisions 1, 2, 2a, 3; 245A.10, subdivision 4; 245A.14, subdivisions 4, 8, by adding subdivisions; 245A.145, subdivisions 1, 2; 245A.151; 245A.16, subdivision 1, by adding a subdivision; 245A.18, subdivision 2; 245A.40; 245A.41; 245A.50; 245A.51, subdivision 3, by adding subdivisions; 245A.66, subdivisions 2, 3; 245C.02, subdivision 6a, by adding subdivisions; 245C.03, subdivision 1, by adding a subdivision; 245C.05, subdivisions 2c, 2d, 4, 5, 5a; 245C.08, subdivisions 1, 3; 245C.10, by adding a subdivision; 245C.13, subdivision 2, by adding a subdivision; 245C.14, subdivision 1; 245C.15, subdivisions 2, 3, 4, by adding a subdivision; 245C.22, subdivisions 4, 5; 245C.24; 245C.30, subdivisions 1, 2, 3; 245C.32, subdivision 2; 245D.03, subdivision 1; 245D.071, subdivision 1; 245D.081, subdivision 3; 245E.01, subdivision 8; 245E.02, by adding a subdivision; 245F.05, subdivision 2; 245H.01, by adding subdivisions; 245H.03, by adding a subdivision; 245H.07; 245H.10, subdivision 1; 245H.11; 245H.12; 245H.13, subdivision 5, by adding subdivisions; 245H.14, subdivisions 1, 3, 4, 5, 6; 245H.15, subdivision 1; 246.54, by adding a subdivision; 246B.10; 252.27, subdivision 2a; 252.275, subdivision 3; 252.28, subdivision 1; 252.41, subdivisions 3, 4, 5, 6, 7, 9; 252.42; 252.43; 252.44; 252.45; 254A.03, subdivision 3; 254B.02, subdivision 1; 254B.03, subdivisions 2, 4; 254B.04, subdivision 1; 254B.05, subdivisions 1a, 5; 254B.06, subdivisions 1, 2; 256.01, subdivision 14b; 256.046, subdivision 1, by adding a subdivision; 256.478; 256.9365; 256.962, subdivision 5; 256.969, subdivisions 2b, 3a, 9, 17, 19; 256.98, subdivision 8; 256B.02, subdivision 7; 256B.04, subdivisions 14, 21, 22; 256B.055, subdivision 2; 256B.056, subdivisions 3, 5c; 256B.0615, subdivision 1; 256B.0616, subdivisions 1, 3; 256B.0622, subdivisions 1, 2, 3a, 4, 5a, 7, 7a, 7b, 7d; 256B.0623,

subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12; 256B.0624, subdivisions 2, 4, 5, 6, 7, 8, 9, 11; 256B.0625, subdivisions 3b, 5, 5l, 9, 13, 13d, 13e, 13f, 17, 19c, 23, 24, 30, 31, 42, 45a, 48, 49, 56a, 57, 61, 62, 65, by adding subdivisions; 256B.064, subdivisions 1a, 1b, 2, by adding subdivisions; 256B.0644; 256B.0651, subdivision 17; 256B.0658; 256B.0659, subdivisions 11, 12, 21, 24, 28, by adding a subdivision; 256B.0757, subdivisions 2, 4, 8, by adding subdivisions; 256B.0915, subdivisions 3a, 3b; 256B.092, subdivision 13; 256B.0941, subdivisions 1, 3; 256B.0943, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 11; 256B.0944, subdivisions 1, 3, 4, 5, 6, 7, 8, 9; 256B.0946, subdivisions 1, 1a, 2, 3, 4, 6; 256B.0947, subdivisions 1, 2, 3, 3a, 5, 6, 7a; 256B.0949, subdivisions 2, 4, 5a, by adding a subdivision; 256B.27, subdivision 3; 256B.434, subdivisions 1, 3; 256B.49, subdivision 24; 256B.4912, by adding subdivisions; 256B.4913, subdivisions 4a, 5; 256B.4914, subdivisions 2, 4, 5, 6, 7, 8, 9, 10, 10a, 14, 15, by adding a subdivision; 256B.69, subdivisions 6, 6d, 35, by adding subdivisions; 256B.76, subdivisions 2, 4; 256B.766; 256B.85, subdivisions 3, 10, 11, 12, 16, by adding a subdivision; 256I.03, subdivision 15; 256I.04, subdivisions 1, 2a, 2f; 256I.05, subdivision 1c; 256I.06, subdivision 8; 256J.24, subdivision 5; 256L.03, by adding a subdivision; 256L.07, subdivision 2, by adding a subdivision; 256L.11, subdivisions 2, 7; 256L.121, subdivision 3; 256M.41, subdivision 3, by adding a subdivision; 256R.02, subdivisions 8, 19, by adding subdivisions; 256R.08, subdivision 1; 256R.10, by adding a subdivision; 256R.16, subdivision 1; 256R.21, by adding a subdivision; 256R.23, subdivision 5; 256R.24; 256R.25; 256R.26; 256R.44; 256R.47; 256R.50, subdivision 6; 260C.007, subdivision 18, by adding a subdivision; 260C.178, subdivision 1; 260C.201, subdivisions 1, 2, 6; 260C.212, subdivision 2; 260C.452, subdivision 4; 260C.503, subdivision 1; 270B.12, by adding a subdivision; 290.0131, by adding a subdivision; 295.51, subdivision 1a; 295.52, subdivision 8; 295.57, subdivision 3; 295.582, subdivision 1; 317A.811, by adding a subdivision; 325F.72, subdivisions 1, 2, 4; 461.12, subdivisions 2, 3, 4, 5, 6, 8; 461.18; 518A.32, subdivision 3; 609.685; 609.6855; 626.556, subdivision 10; 626.5572, subdivision 6; 628.26; 641.15, subdivision 3a; Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6, as amended; Laws 2017, First Special Session chapter 6, article 1, section 45; article 3, section 49; article 5, section 11; article 8, sections 71; 72; proposing coding for new law in Minnesota Statutes, chapters 62A; 62C; 62D; 62K; 62Q; 62V; 119B; 137; 144; 144A; 144G; 145; 148; 151; 245; 245A; 245D; 256; 256B; 256L; 256M; 256R; 260C; 290; 461; 609; proposing coding for new law as Minnesota Statutes, chapters 62W; 144I; 144J; 144K; 245I; 256T; 317B; repealing Minnesota Statutes 2018, sections 62A.021, subdivisions 1, 3; 119B.125, subdivision 8; 119B.16, subdivision 2; 144.414, subdivision 5; 144A.071, subdivision 4d; 144A.441; 144A.442; 144A.45, subdivision 6; 144A.472, subdivision 4; 144A.481; 144D.01; 144D.015; 144D.02; 144D.025; 144D.03; 144D.04; 144D.045; 144D.05; 144D.06; 144D.065; 144D.066; 144D.07; 144D.08; 144D.09; 144D.10; 144D.11; 144G.01; 144G.02; 144G.03; 144G.04; 144G.05; 144G.06; 151.214, subdivision 2; 151.42; 151.44; 151.49; 151.50; 151.51; 151.55; 151.60; 151.61; 151.62; 151.63; 151.64; 151.65; 151.66; 151.67; 151.68; 151.69; 151.70; 151.71; 214.17; 214.18; 214.19; 214.20; 214.21; 214.22; 214.23; 214.24; 245.462, subdivision 4a; 245E.06, subdivisions 2, 4, 5; 245H.10, subdivision 2; 246.18, subdivisions 8, 9; 252.41, subdivision 8; 252.431; 252.451; 254B.03, subdivision 4a; 256B.0615, subdivisions 2, 4, 5; 256B.0616, subdivisions 2, 4, 5; 256B.0624, subdivision 10; 256B.0625, subdivision 63; 256B.0659, subdivision 22; 256B.0705; 256B.0943, subdivision 10; 256B.0944, subdivision 10; 256B.0946, subdivision 5; 256B.0947, subdivision 9; 256B.431, subdivisions 3a, 3f, 3g, 3i, 10, 13, 15, 16, 17, 17a, 17c, 17d, 17e, 18, 21, 22, 30, 45; 256B.434, subdivisions 4, 4f, 4i, 4j, 6, 10; 256B.4913, subdivisions 4a, 6, 7; 256L.11, subdivisions 2a, 6a; 256R.36; 256R.40; 256R.41; Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 10; Laws 2011, First Special Session chapter 9, article 6, section 97, subdivision 6; Minnesota Rules, parts 2960.3030, subpart 3; 3400.0185, subpart 5; 6400.6970; 7200.6100; 7200.6105; 9502.0425, subparts 4, 16, 17; 9503.0155, subpart 8; 9505.0370;

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

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

## ARTICLE 1

## CHILDREN AND FAMILIES

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

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

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

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

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

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

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

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

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

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

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

Subd. 20. **Transition year families.** "Transition year families" means families who have received MFIP assistance, or who were eligible to receive MFIP assistance after choosing to discontinue receipt of the cash portion of MFIP assistance under section 256J.31, subdivision 12, or families who have received DWP assistance under section 256J.95 for at least ~~three~~ one of the last six months before losing eligibility for MFIP or DWP. Notwithstanding Minnesota Rules, parts 3400.0040, subpart 10, and 3400.0090, subpart 2, transition year child care may be used to support employment, approved education or training programs, or job search that meets the requirements of section 119B.10. Transition year child care is not available to families who have been disqualified from MFIP or DWP due to fraud.

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

Sec. 4. Minnesota Statutes 2018, section 119B.02, subdivision 3, is amended to read:

Subd. 3. **Supervision of counties and providers.** (a) The commissioner shall supervise child care programs administered by the counties through standard-setting, technical assistance to the counties, approval of county child care fund plans, and distribution of public money for services. The commissioner shall provide training and other support services to assist counties in planning for and implementing child care assistance programs. The commissioner shall adopt rules under chapter 14 that establish minimum administrative standards for the provision of child care services by county boards of commissioners.

(b) The commissioner shall:

(1) provide technical assistance and training to child care providers about proper billing and attendance record-keeping procedures for reimbursement under this chapter; and

(2) ensure that the training and technical assistance provided to child care providers is linguistically and culturally accessible.

**EFFECTIVE DATE.** This section is effective July 1, 2020.

Sec. 5. Minnesota Statutes 2018, section 119B.02, subdivision 7, is amended to read:

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

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

Sec. 6. Minnesota Statutes 2018, section 119B.025, subdivision 1, is amended to read:

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

(1) identity of adults;

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

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

(4) age;

(5) immigration status, if related to eligibility;

(6) Social Security number, if given;

(7) counted income;

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

(9) residence; and

(10) inconsistent information, if related to eligibility.

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

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

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

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

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

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

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

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

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

Sec. 7. Minnesota Statutes 2018, section 119B.025, is amended by adding a subdivision to read:

Subd. 5. **Information to applicants; child care fraud.** At the time of initial application and at redetermination, the county must provide written notice to the applicant or participant listing the activities that constitute child care fraud and the consequences of committing child care fraud. An applicant or participant shall acknowledge receipt of the child care fraud notice in writing.

**EFFECTIVE DATE.** This section is effective September 1, 2019.

Sec. 8. Minnesota Statutes 2018, section 119B.03, subdivision 9, is amended to read:

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

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

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

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

(c) The receiving county must:

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

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

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

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

Sec. 9. Minnesota Statutes 2018, section 119B.05, subdivision 1, is amended to read:

Subdivision 1. **Eligible participants.** Families eligible for child care assistance under the MFIP child care program are:

(1) MFIP participants who are employed or in job search and meet the requirements of section 119B.10;

(2) persons who are members of transition year families under section 119B.011, subdivision 20, and meet the requirements of section 119B.10;

(3) families who are participating in employment orientation or job search, or other employment or training activities that are included in an approved employability development plan under section 256J.95;

(4) MFIP families who are participating in work job search, job support, employment, or training activities as required in their employment plan, or in appeals, hearings, assessments, or orientations according to chapter 256J;

(5) MFIP families who are participating in social services activities under chapter 256J as required in their employment plan approved according to chapter 256J;

(6) families who are participating in services or activities that are included in an approved family stabilization plan under section 256J.575;

(7) families who are participating in programs as required in tribal contracts under section 119B.02, subdivision 2, or 256.01, subdivision 2;

(8) families who are participating in the transition year extension under section 119B.011, subdivision 20a;

(9) student parents as defined under section 119B.011, subdivision 19b; ~~and~~

(10) student parents who turn 21 years of age and who continue to meet the other requirements under section 119B.011, subdivision 19b. A student parent continues to be eligible until the student parent is approved for basic sliding fee child care assistance or until the student parent's redetermination, whichever comes first. At the student parent's redetermination, if the student parent was not approved for basic sliding fee child care assistance, a student parent's eligibility ends following a 15-day adverse action notice.; and

(11) MFIP child-only cases under section 256J.88, for up to 20 hours of child care per week for children six years of age and younger, as recommended by the treating mental health professional, when either the child's primary caregiver has a diagnosis of a mental illness and is in need of intensive treatment, or the child is in need of a consistent caregiver.

Sec. 10. Minnesota Statutes 2018, section 119B.09, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

Sec. 11. Minnesota Statutes 2018, section 119B.095, subdivision 2, is amended to read:

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

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

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

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

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

(1) the child's school schedule;

(2) the custody schedule; or

(3) the provider's availability.

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

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

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

Sec. 12. Minnesota Statutes 2018, section 119B.095, is amended by adding a subdivision to read:

Subd. 3. **Assistance for persons who are homeless.** An applicant who is homeless and eligible for child care assistance is exempt from the activity participation requirements under this chapter for three months. The applicant under this subdivision is eligible for 60 hours of child care assistance per service period for three months from the date the county receives the application. Additional hours may be authorized as needed based on the applicant's participation in employment, education, or MFIP or DWP employment plan. To continue receiving child care assistance after the initial three months, the applicant must verify that the applicant meets eligibility and activity requirements for child care assistance under this chapter.

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

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

Subdivision 1. **Subsidy restrictions.** (a) Beginning ~~February 3, 2014,~~ September 20, 2019, the maximum rate paid for child care assistance in any county or county price cluster under the child care fund shall be the greater of the 25th percentile of the ~~2011~~ 2018 child care provider rate survey under section 119B.02, subdivision 7, or the maximum rate effective ~~November 28, 2011~~ February 3, 2014. For a child care provider located within the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum rate paid for child care assistance shall be equal to the maximum rate paid in the county with the highest maximum reimbursement rates or the provider's charge, whichever is less. The commissioner may: (1) assign a county with no reported provider prices to a similar price cluster; and (2) consider county level access when determining final price clusters.

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

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

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

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

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

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

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

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

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

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

(i) ~~Notwithstanding Minnesota Rules, part 3400.0130, subpart 7, maximum registration fees in effect on January 1, 2013, shall remain in effect.~~ The maximum registration fee paid for child care assistance in any county or county price cluster under the child care fund shall be the greater of the 25th percentile of the 2018 child care provider rate survey under section 119B.02, subdivision 7, or the registration fee in effect February 3, 2014. Maximum registration fees must be set for licensed family child care and for child care centers. For a child care provider located within the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum registration fee paid for child care assistance shall be equal to the maximum registration fee paid in the county with the highest maximum registration fee or the provider's charge, whichever is less.

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

Sec. 14. Minnesota Statutes 2018, section 119B.16, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

(5) initiates an administrative fraud disqualification hearing; or

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

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

(d) The provider's appeal request must contain the following:

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

(2) the computation the provider believes to be correct, if applicable;

(3) the statute or rule relied on for each disputed item; and

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

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

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

Subd. 1b. **Joint fair hearings.** ~~When a provider requests a fair hearing under subdivision 1a, the family in whose case the overpayment was created must be made a party to the fair hearing. All other issues raised by the family must be resolved in the same proceeding. When a family requests a fair hearing and claims that the county should have assigned responsibility for an overpayment to a provider, the provider must be made a party to the fair hearing.~~ The human services judge assigned to a fair hearing may join a family or a provider as a party to the fair hearing whenever joinder of that party is necessary to fully and fairly resolve ~~overpayment~~ issues raised in the appeal.

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

Sec. 17. Minnesota Statutes 2018, section 119B.16, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

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

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

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

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

Sec. 20. **[119B.161] ADMINISTRATIVE REVIEW.**

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

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

(b) The notice must:

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 21. **[119B.195] RETAINING EARLY EDUCATORS THROUGH ATTAINING INCENTIVES NOW (REETAIN) GRANT PROGRAM.**

Subdivision 1. **Establishment; purpose.** The retaining early educators through attaining incentives now (REETAIN) grant program is established to provide competitive grants to incentivize well-trained child care professionals to stay in the workforce to create more consistent care for children over time.

Subd. 2. **Administration.** (a) The commissioner must administer the REETAIN grant program, and must provide a grant to a nonprofit organization with demonstrated ability to manage benefit programs for child care professionals.

(b) Up to ten percent of grant funds may be used for administration of the grant program.

Subd. 3. **Application.** Applicants must apply for the REETAIN grant program in the manner and according to the timelines established by the commissioner.

Subd. 4. **Eligibility.** (a) Applicants must:

(1) be licensed to provide child care or work for a licensed child care program;

(2) work directly with children at least 30 hours per week;

(3) be in their current position for at least 12 months;

(4) be willing to stay in their current position for at least 12 months after receiving a grant under this section;

(5) have a career lattice step of five or higher;

(6) have a current membership with the Minnesota quality improvement and registry tool; and

(7) meet any other requirements established by the commissioner.

(b) Grant recipients must sign a contract agreeing to remain in their current position for 12 months.

Subd. 5. **Grant awards.** (a) To the extent that funding is available, a child care professional's annual amount for the REETAIN grant must not exceed an amount determined by the commissioner. A child care professional must apply each year to compete for an award, and may receive up to one award per year.

(b) Grant funds may be used for program supplies, training, or personal expenses.

Subd. 6. **Report.** Annually by January 1, the commissioner must report to the legislative committees with jurisdiction over early childhood on the number of grants awarded and outcomes of the grant program.

**EFFECTIVE DATE; APPLICATION.** This section is effective July 1, 2019. The first report under subdivision 6 is due by January 1, 2021.

Sec. 22. Minnesota Statutes 2018, section 245C.32, subdivision 2, is amended to read:

Subd. 2. **Use.** (a) The commissioner may also use these systems and records to obtain and provide criminal history data from the Bureau of Criminal Apprehension, criminal history data held by the commissioner, and data about substantiated maltreatment under section 626.556 or 626.557, for other purposes, provided that:

(1) the background study is specifically authorized in statute; or

(2) the request is made with the informed consent of the subject of the study as provided in section 13.05, subdivision 4.

(b) An individual making a request under paragraph (a), clause (2), must agree in writing not to disclose the data to any other individual without the consent of the subject of the data.

(c) The commissioner may recover the cost of obtaining and providing background study data by charging the individual or entity requesting the study a fee of no more than $20 per study. The fees collected under this paragraph are appropriated to the commissioner for the purpose of conducting background studies.

(d) The commissioner shall recover the cost of obtaining background study data required under section 524.5-118 through a fee of $50 per study for an individual who has not lived outside Minnesota for the past ten years, and a fee of $100 for an individual who has resided outside of Minnesota for any period during the ten years preceding the background study. The commissioner shall recover, from the individual, any additional fees charged by other states' licensing agencies that are associated with these data requests. Fees under subdivision 3 also apply when criminal history data from the National Criminal Records Repository is required.

(e) According to paragraph (a), the commissioner shall use the systems and records described in this chapter to provide summary data about maltreatment under sections 626.556 or 626.557 to government entities seeking this data for the purposes of child protection.

Sec. 23. Minnesota Statutes 2018, section 256.01, subdivision 14b, is amended to read:

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

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

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

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

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

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

(4)(i) have capacity to respond to reports of abuse and neglect under section 626.556; or (ii) have codified the tribe's screening, investigation, and assessment of reports of child maltreatment procedures, if authorized to use an alternative method by the commissioner under paragraph (a);

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

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

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

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

(2) family preservation;

(3) facilitative, supportive, and reunification services;

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

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

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

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

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

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

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

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

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

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

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

Sec. 24. Minnesota Statutes 2018, section 256J.24, subdivision 5, is amended to read:

Subd. 5. **MFIP transitional standard.** (a) The MFIP transitional standard is based on the number of persons in the assistance unit eligible for both food and cash assistance. The amount of the transitional standard is published annually by the Department of Human Services.

(b) The amount of the MFIP cash assistance portion of the transitional standard is increased $100 per month per household. This increase shall be reflected in the MFIP cash assistance portion of the transitional standard published annually by the commissioner.

**EFFECTIVE DATE.** This section is effective February 1, 2020.

Sec. 25. Minnesota Statutes 2018, section 256M.41, subdivision 3, is amended to read:

Subd. 3. **Payments ~~based on performance.~~** ~~(a)~~ The commissioner shall make payments under this section to each county ~~board on a calendar year basis in an amount determined under paragraph (b)~~ on or before July 10 of each year.

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

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

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

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

~~(c) The commissioner shall work with stakeholders and the Human Services Performance Council under section 402A.16 to develop recommendations for specific outcome measures that counties should meet in order to receive funds withheld under paragraph (b), and include~~

~~in those recommendations a determination as to whether the performance measures under paragraph (b) should be modified or phased out. The commissioner shall report the recommendations to the legislative committees having jurisdiction over child protection issues by January 1, 2018.~~

Sec. 26. Minnesota Statutes 2018, section 256M.41, is amended by adding a subdivision to read:

Subd. 4. **County performance on child protection measures.** The commissioner shall set child protection measures and standards. The commissioner shall require an underperforming county to demonstrate that the county designated sufficient funds and implemented a reasonable strategy to improve child protection performance, including the provision of a performance improvement plan and additional remedies identified by the commissioner. The commissioner may redirect up to 20 percent of a county's funds under this section toward the performance improvement plan. Sanctions under section 256M.20, subdivision 3, related to noncompliance with federal performance standards also apply.

Sec. 27. Minnesota Statutes 2018, section 260C.007, subdivision 18, is amended to read:

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

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

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

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

(b) A child is in foster care under this definition regardless of whether the facility is licensed and payments are made for the cost of care. Nothing in this definition creates any authority to place a child in a home or facility that is required to be licensed which is not licensed. "Foster care" does not include placement in any of the following facilities: hospitals, inpatient chemical dependency treatment facilities where the child is the recipient of the

treatment, facilities that are primarily for delinquent children, any corrections facility or program within a particular correction's facility not meeting requirements for title IV-E facilities as determined by the commissioner, facilities to which a child is committed under the provision of chapter 253B, forestry camps, or jails. Foster care is intended to provide for a child's safety or to access treatment. Foster care must not be used as a punishment or consequence for a child's behavior.

Sec. 28. Minnesota Statutes 2018, section 260C.007, is amended by adding a subdivision to read:

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

Sec. 29. Minnesota Statutes 2018, section 260C.178, subdivision 1, is amended to read:

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

(b) Unless there is reason to believe that the child would endanger self or others or not return for a court hearing, or that the child's health or welfare would be immediately endangered, the child shall be released to the custody of a parent, guardian, custodian, or other suitable person, subject to reasonable conditions of release including, but not limited to, a requirement that the child undergo a chemical use assessment as provided in section 260C.157, subdivision 1.

(c) If the court determines there is reason to believe that the child would endanger self or others or not return for a court hearing, or that the child's health or welfare would be immediately endangered if returned to the care of the parent or guardian who has custody and from whom the child was removed, the court shall order the child into foster care as defined in section 260C.007, subdivision 18, under the legal responsibility of the responsible social services agency or responsible probation or corrections agency for the purposes of

protective care as that term is used in the juvenile court rules or into the home of a noncustodial parent and order the noncustodial parent to comply with any conditions the court determines to be appropriate to the safety and care of the child, including cooperating with paternity establishment proceedings in the case of a man who has not been adjudicated the child's father. The court shall not give the responsible social services legal custody and order a trial home visit at any time prior to adjudication and disposition under section 260C.201, subdivision 1, paragraph (a), clause (3), but may order the child returned to the care of the parent or guardian who has custody and from whom the child was removed and order the parent or guardian to comply with any conditions the court determines to be appropriate to meet the safety, health, and welfare of the child.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) If the county attorney has filed a petition under section 260C.307, the court shall schedule a trial under section 260C.163 within 90 days of the filing of the petition except

when the county attorney determines that the criminal case shall proceed to trial first under section 260C.503, subdivision 2, paragraph (c).

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

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

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

Sec. 30. **[260C.190] FAMILY-FOCUSED RESIDENTIAL PLACEMENT.**

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

(b) During the child's placement under paragraph (a), the agency: (1) may visit the child as the agency deems necessary and appropriate; (2) shall continue to have access to

information under section 260C.208; and (3) shall continue to provide appropriate services to both the parent and the child.

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

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

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

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

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

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

(d) The court shall make findings regarding the reasonable efforts of the agency to finalize the child's return home as the permanency disposition order in the child's best

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

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

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

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

(h) If a parent leaves or is discharged from a licensed residential family-based substance use disorder treatment program without completing the program and the child is colocated with a parent and the child has been in foster care for more than 12 months, the court shall begin permanency proceedings under sections 260C.503 to 260C.521.

Sec. 31. Minnesota Statutes 2018, section 260C.201, subdivision 1, is amended to read:

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

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

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

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

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

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

(i) a child-placing agency; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) if the court believes that it is in the best interests of the child or of public safety that the child's driver's license or instruction permit be canceled, the court may order the commissioner of public safety to cancel the child's license or permit for any period up to the child's 18th birthday. If the child does not have a driver's license or permit, the court may order a denial of driving privileges for any period up to the child's 18th birthday. The court shall forward an order issued under this clause to the commissioner, who shall cancel the license or permit or deny driving privileges without a hearing for the period specified by the court. At any time before the expiration of the period of cancellation or denial, the court may, for good cause, order the commissioner of public safety to allow the child to apply for a license or permit, and the commissioner shall so authorize;

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

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

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

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

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

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

Sec. 32. Minnesota Statutes 2018, section 260C.201, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

(5) if the child has been adjudicated as a child in need of protection or services because the child is in need of special services or care to treat or ameliorate a mental disability or

emotional disturbance as defined in section 245.4871, subdivision 15, the written findings shall also set forth:

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

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

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

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

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

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

Sec. 33. Minnesota Statutes 2018, section 260C.201, subdivision 6, is amended to read:

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

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

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

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

Sec. 34. Minnesota Statutes 2018, section 260C.212, subdivision 2, is amended to read:

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

(1) with an individual who is related to the child by blood, marriage, or adoption; or

(2) with an individual who is an important friend with whom the child has resided or had significant contact.

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

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

(1) the child's current functioning and behaviors;

(2) the medical needs of the child;

(3) the educational needs of the child;

(4) the developmental needs of the child;

(5) the child's history and past experience;

(6) the child's religious and cultural needs;

(7) the child's connection with a community, school, and faith community;

(8) the child's interests and talents;

(9) the child's relationship to current caretakers, parents, siblings, and relatives;

(10) the reasonable preference of the child, if the court, or the child-placing agency in the case of a voluntary placement, deems the child to be of sufficient age to express preferences; and

(11) for an Indian child, the best interests of an Indian child as defined in section 260.755, subdivision 2a.

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

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

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

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

Sec. 35. **[260C.228] VOLUNTARY FOSTER CARE; CHILD IS COLOCATED WITH PARENT IN TREATMENT PROGRAM.**

Subdivision 1. **Generally.** When a parent requests assistance from an agency and both the parent and agency agree that a child's placement in foster care and colocation with a parent in a licensed residential family-based substance use treatment facility as defined by section 260C.007, subdivision 22a, is in the child's best interests, the agency must specify the recommendation for the placement in the child's case plan. After the child's case plan

includes the recommendation, the agency and the parent may enter into a written voluntary placement agreement on a form approved by the commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) If the court finds continuing the voluntary foster care arrangement is not in the child's best interests or that the agency or the parent is not appropriately planning for the child, the

court shall notify the agency, the parent, the licensed residential family-based substance use disorder treatment program, a child 12 years of age or older, and the county attorney of the court's determination and the basis for the court's determination. The court shall set the matter for hearing and appoint a guardian ad litem for the child under section 260C.163, subdivision 5.

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

Sec. 36. Minnesota Statutes 2018, section 260C.452, subdivision 4, is amended to read:

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

(b) The responsible social services agency shall file a copy of the notification required in subdivision 3 with the court. If the responsible social services agency does not file the notice by the time the child is 17-1/2 years of age, the court shall require the responsible social services agency to file the notice.

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

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

(1) affordable housing with necessary supports that does not include a homeless shelter;

(2) health insurance, including eligibility for medical assistance as defined in section 256B.055, subdivision 17;

(3) education, including application to the Education and Training Voucher Program;

(4) local opportunities for mentors and continuing support services, including the Healthy Transitions and Homeless Prevention program, if available;

(5) workforce supports and employment services;

(6) a copy of the child's consumer credit report as defined in section 13C.001 and assistance in interpreting and resolving any inaccuracies in the report, at no cost to the child;

(7) information on executing a health care directive under chapter 145C and on the importance of designating another individual to make health care decisions on behalf of the child if the child becomes unable to participate in decisions; ~~and~~

(8) appropriate contact information through 21 years of age if the child needs information or help dealing with a crisis situation~~.~~; and

(9) official documentation that the youth was previously in foster care.

Sec. 37. Minnesota Statutes 2018, section 260C.503, subdivision 1, is amended to read:

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

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

Sec. 38. Minnesota Statutes 2018, section 518A.32, subdivision 3, is amended to read:

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

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

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

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

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

Sec. 39. Minnesota Statutes 2018, section 626.556, subdivision 10, is amended to read:

Subd. 10. **Duties of local welfare agency and local law enforcement agency upon receipt of report; mandatory notification between police or sheriff and agency.** (a) The police department or the county sheriff shall immediately notify the local welfare agency or agency responsible for child protection reports under this section orally and in writing when a report is received. The local welfare agency or agency responsible for child protection reports shall immediately notify the local police department or the county sheriff orally and in writing when a report is received. The county sheriff and the head of every local welfare agency, agency responsible for child protection reports, and police department shall each designate a person within their agency, department, or office who is responsible for ensuring that the notification duties of this paragraph are carried out. When the alleged maltreatment occurred on tribal land, the local welfare agency or agency responsible for child protection reports and the local police department or the county sheriff shall immediately notify the tribe's social services agency and tribal law enforcement orally and in writing when a report is received.

(b) Upon receipt of a report, the local welfare agency shall determine whether to conduct a family assessment or an investigation as appropriate to prevent or provide a remedy for child maltreatment. The local welfare agency:

(1) shall conduct an investigation on reports involving sexual abuse or substantial child endangerment;

(2) shall begin an immediate investigation if, at any time when it is using a family assessment response, it determines that there is reason to believe that sexual abuse or substantial child endangerment or a serious threat to the child's safety exists;

(3) may conduct a family assessment for reports that do not allege sexual abuse or substantial child endangerment. In determining that a family assessment is appropriate, the local welfare agency may consider issues of child safety, parental cooperation, and the need for an immediate response;

(4) may conduct a family assessment on a report that was initially screened and assigned for an investigation. In determining that a complete investigation is not required, the local welfare agency must document the reason for terminating the investigation and notify the local law enforcement agency if the local law enforcement agency is conducting a joint investigation; and

(5) shall provide immediate notice, according to section 260.761, subdivision 2, to an Indian child's tribe when the agency has reason to believe the family assessment or investigation may involve an Indian child. For purposes of this clause, "immediate notice" means notice provided within 24 hours.

If the report alleges neglect, physical abuse, or sexual abuse by a parent, guardian, or individual functioning within the family unit as a person responsible for the child's care, or sexual abuse by a person with a significant relationship to the child when that person resides in the child's household or by a sibling, the local welfare agency shall immediately conduct a family assessment or investigation as identified in clauses (1) to (4). In conducting a family assessment or investigation, the local welfare agency shall gather information on the existence of substance abuse and domestic violence and offer services for purposes of preventing future child maltreatment, safeguarding and enhancing the welfare of the abused or neglected minor, and supporting and preserving family life whenever possible. If the report alleges a violation of a criminal statute involving sexual abuse, physical abuse, or neglect or endangerment, under section 609.378, the local law enforcement agency and local welfare agency shall coordinate the planning and execution of their respective investigation and assessment efforts to avoid a duplication of fact-finding efforts and multiple interviews. Each agency shall prepare a separate report of the results of its investigation or assessment. In cases of alleged child maltreatment resulting in death, the local agency may rely on the fact-finding efforts of a law enforcement investigation to make a determination of whether or not maltreatment occurred. When necessary the local welfare agency shall seek authority to remove the child from the custody of a parent, guardian, or adult with whom the child is living. In performing any of these duties, the local welfare agency shall maintain appropriate records.

If the family assessment or investigation indicates there is a potential for abuse of alcohol or other drugs by the parent, guardian, or person responsible for the child's care, the local

welfare agency shall conduct a chemical use assessment pursuant to Minnesota Rules, part 9530.6615.

(c) When a local agency receives a report or otherwise has information indicating that a child who is a client, as defined in section 245.91, has been the subject of physical abuse, sexual abuse, or neglect at an agency, facility, or program as defined in section 245.91, it shall, in addition to its other duties under this section, immediately inform the ombudsman established under sections 245.91 to 245.97. The commissioner of education shall inform the ombudsman established under sections 245.91 to 245.97 of reports regarding a child defined as a client in section 245.91 that maltreatment occurred at a school as defined in section 120A.05, subdivisions 9, 11, and 13, and chapter 124E.

(d) Authority of the local welfare agency responsible for assessing or investigating the child abuse or neglect report, the agency responsible for assessing or investigating the report, and of the local law enforcement agency for investigating the alleged abuse or neglect includes, but is not limited to, authority to interview, without parental consent, the alleged victim and any other minors who currently reside with or who have resided with the alleged offender. The interview may take place at school or at any facility or other place where the alleged victim or other minors might be found or the child may be transported to, and the interview conducted at, a place appropriate for the interview of a child designated by the local welfare agency or law enforcement agency. The interview may take place outside the presence of the alleged offender or parent, legal custodian, guardian, or school official. For family assessments, it is the preferred practice to request a parent or guardian's permission to interview the child prior to conducting the child interview, unless doing so would compromise the safety assessment. Except as provided in this paragraph, the parent, legal custodian, or guardian shall be notified by the responsible local welfare or law enforcement agency no later than the conclusion of the investigation or assessment that this interview has occurred. Notwithstanding rule 32 of the Minnesota Rules of Procedure for Juvenile Courts, the juvenile court may, after hearing on an ex parte motion by the local welfare agency, order that, where reasonable cause exists, the agency withhold notification of this interview from the parent, legal custodian, or guardian. If the interview took place or is to take place on school property, the order shall specify that school officials may not disclose to the parent, legal custodian, or guardian the contents of the notification of intent to interview the child on school property, as provided under this paragraph, and any other related information regarding the interview that may be a part of the child's school record. A copy of the order shall be sent by the local welfare or law enforcement agency to the appropriate school official.

(e) When the local welfare, local law enforcement agency, or the agency responsible for assessing or investigating a report of maltreatment determines that an interview should take place on school property, written notification of intent to interview the child on school property must be received by school officials prior to the interview. The notification shall include the name of the child to be interviewed, the purpose of the interview, and a reference to the statutory authority to conduct an interview on school property. For interviews conducted by the local welfare agency, the notification shall be signed by the chair of the local social services agency or the chair's designee. The notification shall be private data on individuals subject to the provisions of this paragraph. School officials may not disclose to the parent, legal custodian, or guardian the contents of the notification or any other related information regarding the interview until notified in writing by the local welfare or law enforcement agency that the investigation or assessment has been concluded, unless a school employee or agent is alleged to have maltreated the child. Until that time, the local welfare or law enforcement agency or the agency responsible for assessing or investigating a report of maltreatment shall be solely responsible for any disclosures regarding the nature of the assessment or investigation.

Except where the alleged offender is believed to be a school official or employee, the time and place, and manner of the interview on school premises shall be within the discretion of school officials, but the local welfare or law enforcement agency shall have the exclusive authority to determine who may attend the interview. The conditions as to time, place, and manner of the interview set by the school officials shall be reasonable and the interview shall be conducted not more than 24 hours after the receipt of the notification unless another time is considered necessary by agreement between the school officials and the local welfare or law enforcement agency. Where the school fails to comply with the provisions of this paragraph, the juvenile court may order the school to comply. Every effort must be made to reduce the disruption of the educational program of the child, other students, or school staff when an interview is conducted on school premises.

(f) Where the alleged offender or a person responsible for the care of the alleged victim or other minor prevents access to the victim or other minor by the local welfare agency, the juvenile court may order the parents, legal custodian, or guardian to produce the alleged victim or other minor for questioning by the local welfare agency or the local law enforcement agency outside the presence of the alleged offender or any person responsible for the child's care at reasonable places and times as specified by court order.

(g) Before making an order under paragraph (f), the court shall issue an order to show cause, either upon its own motion or upon a verified petition, specifying the basis for the

requested interviews and fixing the time and place of the hearing. The order to show cause shall be served personally and shall be heard in the same manner as provided in other cases in the juvenile court. The court shall consider the need for appointment of a guardian ad litem to protect the best interests of the child. If appointed, the guardian ad litem shall be present at the hearing on the order to show cause.

(h) The commissioner of human services, the ombudsman for mental health and developmental disabilities, the local welfare agencies responsible for investigating reports, the commissioner of education, and the local law enforcement agencies have the right to enter facilities as defined in subdivision 2 and to inspect and copy the facility's records, including medical records, as part of the investigation. Notwithstanding the provisions of chapter 13, they also have the right to inform the facility under investigation that they are conducting an investigation, to disclose to the facility the names of the individuals under investigation for abusing or neglecting a child, and to provide the facility with a copy of the report and the investigative findings.

(i) The local welfare agency responsible for conducting a family assessment or investigation shall collect available and relevant information to determine child safety, risk of subsequent child maltreatment, and family strengths and needs and share not public information with an Indian's tribal social services agency without violating any law of the state that may otherwise impose duties of confidentiality on the local welfare agency in order to implement the tribal state agreement. The local welfare agency or the agency responsible for investigating the report shall collect available and relevant information to ascertain whether maltreatment occurred and whether protective services are needed. Information collected includes, when relevant, information with regard to the person reporting the alleged maltreatment, including the nature of the reporter's relationship to the child and to the alleged offender, and the basis of the reporter's knowledge for the report; the child allegedly being maltreated; the alleged offender; the child's caretaker; and other collateral sources having relevant information related to the alleged maltreatment. As a part of determining whether child protective services are needed, the local welfare agency responsible for conducting the family assessment or investigation shall submit a request to the commissioner of human services to collect child abuse and neglect records maintained in each state other than Minnesota where the alleged offender has resided in the preceding five years. The commissioner shall send out-of-state child abuse and neglect records inquiries to the relevant states within three business days of receiving the request from the local welfare agency. The commissioner shall forward the results of these inquiries to the local welfare agency responsible for conducting the family assessment or investigation as they

are received. The commissioner shall inform the local welfare agency if the commissioner does not receive a response from all states with records required to be searched within 20 business days. The local welfare agency or the agency responsible for investigating the report may make a determination of no maltreatment early in an investigation, and close the case and retain immunity, if the collected information shows no basis for a full investigation.

Information relevant to the assessment or investigation must be asked for, and may include:

(1) the child's sex and age; prior reports of maltreatment, including any maltreatment reports that were screened out and not accepted for assessment or investigation; information relating to developmental functioning; credibility of the child's statement; and whether the information provided under this clause is consistent with other information collected during the course of the assessment or investigation;

(2) the alleged offender's age~~,~~ and a record check for prior ~~reports of maltreatment, and~~ criminal charges and convictions. The local welfare agency or the agency responsible for assessing or investigating the report must provide the alleged offender with an opportunity to make a statement. The alleged offender may submit supporting documentation relevant to the assessment or investigation;

(3) collateral source information regarding the alleged maltreatment and care of the child. Collateral information includes, when relevant: (i) a medical examination of the child; (ii) prior medical records relating to the alleged maltreatment or the care of the child maintained by any facility, clinic, or health care professional and an interview with the treating professionals; and (iii) interviews with the child's caretakers, including the child's parent, guardian, foster parent, child care provider, teachers, counselors, family members, relatives, and other persons who may have knowledge regarding the alleged maltreatment and the care of the child; and

(4) information on the existence of domestic abuse and violence in the home of the child, and substance abuse.

Nothing in this paragraph precludes the local welfare agency, the local law enforcement agency, or the agency responsible for assessing or investigating the report from collecting other relevant information necessary to conduct the assessment or investigation. Notwithstanding sections 13.384 or 144.291 to 144.298, the local welfare agency has access to medical data and records for purposes of clause (3). Notwithstanding the data's classification in the possession of any other agency, data acquired by the local welfare

agency or the agency responsible for assessing or investigating the report during the course of the assessment or investigation are private data on individuals and must be maintained in accordance with subdivision 11. Data of the commissioner of education collected or maintained during and for the purpose of an investigation of alleged maltreatment in a school are governed by this section, notwithstanding the data's classification as educational, licensing, or personnel data under chapter 13.

In conducting an assessment or investigation involving a school facility as defined in subdivision 2, paragraph (c), the commissioner of education shall collect investigative reports and data that are relevant to a report of maltreatment and are from local law enforcement and the school facility.

(j) Upon receipt of a report, the local welfare agency shall conduct a face-to-face contact with the child reported to be maltreated and with the child's primary caregiver sufficient to complete a safety assessment and ensure the immediate safety of the child. The face-to-face contact with the child and primary caregiver shall occur immediately if sexual abuse or substantial child endangerment is alleged and within five calendar days for all other reports. If the alleged offender was not already interviewed as the primary caregiver, the local welfare agency shall also conduct a face-to-face interview with the alleged offender in the early stages of the assessment or investigation. At the initial contact, the local child welfare agency or the agency responsible for assessing or investigating the report must inform the alleged offender of the complaints or allegations made against the individual in a manner consistent with laws protecting the rights of the person who made the report. The interview with the alleged offender may be postponed if it would jeopardize an active law enforcement investigation.

(k) When conducting an investigation, the local welfare agency shall use a question and answer interviewing format with questioning as nondirective as possible to elicit spontaneous responses. For investigations only, the following interviewing methods and procedures must be used whenever possible when collecting information:

(1) audio recordings of all interviews with witnesses and collateral sources; and

(2) in cases of alleged sexual abuse, audio-video recordings of each interview with the alleged victim and child witnesses.

(l) In conducting an assessment or investigation involving a school facility as defined in subdivision 2, paragraph (c), the commissioner of education shall collect available and relevant information and use the procedures in paragraphs (j) and (k), and subdivision 3d, except that the requirement for face-to-face observation of the child and face-to-face interview

of the alleged offender is to occur in the initial stages of the assessment or investigation provided that the commissioner may also base the assessment or investigation on investigative reports and data received from the school facility and local law enforcement, to the extent those investigations satisfy the requirements of paragraphs (j) and (k), and subdivision 3d.

Sec. 40. **TITLE.**

Sections .... and .... shall be known as "Heaven's Law."

Sec. 41. **INTERSTATE TRANSFER OF CHILD PROTECTION DATA.**

The commissioner of human services is directed to investigate and report to the legislature on potential improvements and advancements in the sharing of child maltreatment data between states, including consideration for interstate compacts or interstate agreements to improve access to child maltreatment investigative and determination data to protect the welfare of children in Minnesota and throughout the country. The commissioner shall report to the legislature on challenges and solutions to the sharing of data on child maltreatment between states no later than February 1, 2020.

Sec. 42. **INSTRUCTION TO COMMISSIONER.**

All individuals in connection with a licensed children's residential facility required to complete a background study under Minnesota Statutes, chapter 245C, must complete a new background study consistent with the obligations and requirements of this article. The commissioner of human services shall establish a schedule for (1) individuals in connection with a licensed children's residential facility that serves children eligible to receive federal Title IV-E funding to complete the new background study by March 1, 2020, and (2) individuals in connection with a licensed children's residential facility that serves children not eligible to receive federal Title IV-E funding to complete the new background study by March 1, 2021.

Sec. 43. **CHILD WELFARE TRAINING ACADEMY.**

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

Subd. 2. **Administration.** (a) The Child Welfare Training Academy must be administered through five regional hubs in northwest, northeast, southwest, southeast, and central

Minnesota. Each hub must deliver training targeted to the needs of the hub's particular region, taking into account varying demographics, resources, and practice outcomes.

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

(c) Content of training delivered by the Child Welfare Training Academy must be informed using multidisciplinary approaches and must include input from stakeholders, including but not limited to child welfare professionals, resource parents, biological parents and caregivers, and other community members with expertise in child welfare racial disparities and implicit bias. Content must be structured to reflect the variety of communities served by the child welfare system in Minnesota and must be informed with attention to both child safety and the evidence-based understanding that maintaining family relationships and preventing out-of-home placement are essential to child well-being. Training delivered by the Child Welfare Training Academy must emphasize racial disparities and disproportionate child welfare outcomes that exist in Minnesota and must include specific content on recognizing and addressing implicit bias.

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

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

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

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

Sec. 44. **CHILD WELFARE CASELOAD STUDY.**

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

of time that child welfare workers spend on different components of child welfare work. The study must be completed by October 1, 2020.

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

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

Sec. 45. **FIRST CHILDREN'S FINANCE CHILD CARE SITE ASSISTANCE.**

Subdivision 1. **Purposes.** Grants to First Children's Finance are for loans to improve child care or early childhood education sites, or loans to plan, design, and construct or expand licensed and legal nonlicensed sites to increase the availability of child care or early childhood education.

Subd. 2. **Financing program.** (a) First Children's Finance must use grant funds to:

(1) establish a revolving loan fund to make loans to existing, expanding, and newly licensed and legally unlicensed child care and early childhood education sites;

(2) establish a fund to guarantee private loans to improve or construct a child care or early childhood education site;

(3) establish a fund to provide forgivable loans or grants to match all or part of a loan made under this section;

(4) establish a fund as a reserve against bad debt; and

(5) establish a fund to provide business planning assistance for child care providers.

(b) First Children's Finance must establish the terms and conditions for loans and loan guarantees including interest rates, repayment agreements, private match requirements, and conditions for loan forgiveness. A minimum interest rate for loans must be established to ensure that necessary loan administration costs are covered. Interest earnings may be used for administrative expenses.

Subd. 3. **Reporting.** First Children's Finance must:

(1) by September 30, 2020, and September 30, 2021, report to the commissioner of human services the purposes for which the money was used during the past fiscal year, including a description of projects supported by the financing, an account of loans made

during the calendar year, the financing program's assets and liabilities, and an explanation of administrative expenses; and

(2) submit to the commissioner of human services a copy of the report of an independent audit performed in accordance with generally accepted accounting practices and auditing standards, for each fiscal year in which grants are received.

Sec. 46. **DIRECTION TO COMMISSIONER; HOMELESS YOUTH ACCESS TO BIRTH RECORDS AND MINNESOTA IDENTIFICATION CARDS.**

No later than January 15, 2020, the commissioner of human services, in consultation with the commissioners of health and public safety, shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over the Homeless Youth Act with recommendations on providing homeless youth with access to birth records and Minnesota identification cards at no cost.

Sec. 47. **DIRECTION TO COMMISSIONER; FAMILY FIRST PREVENTION KINSHIP SERVICES.**

The commissioner of human services shall review opportunities to implement kinship navigator models that support placement of children with relative foster parents in anticipation of reimbursement for eligible services under the Family First Prevention Services Act. Kinship navigator models would assist relative foster parents with home studies and licensing requirements and provide ongoing support to the relative caregivers and children in out-of-home placement with relatives.

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

Sec. 48. **DIRECTION TO COMMISSIONER; RELATIVE SEARCH.**

The commissioner of human services shall develop and provide guidance to assist local social services agencies in conducting relative searches under Minnesota Statutes, section 260C.221. The commissioner shall issue a bulletin containing relative search guidance by January 1, 2020. Guidance from the commissioner shall relate to:

(1) easily understandable methods of relative notification;

(2) resources for local social services agency child welfare staff to improve engagement and communication with relatives and kin; and

(3) providing information to relatives and kin about all permanency options, sustaining relationships, visitation options, and supporting permanency.

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

Sec. 49. **REPEALER.**

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

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

## ARTICLE 2
## OPERATIONS

Section 1. Minnesota Statutes 2018, section 13.46, subdivision 2, is amended to read:

Subd. 2. **General.** (a) Data on individuals collected, maintained, used, or disseminated by the welfare system are private data on individuals, and shall not be disclosed except:

(1) according to section 13.05;

(2) according to court order;

(3) according to a statute specifically authorizing access to the private data;

(4) to an agent of the welfare system and an investigator acting on behalf of a county, the state, or the federal government, including a law enforcement person or attorney in the investigation or prosecution of a criminal, civil, or administrative proceeding relating to the administration of a program;

(5) to personnel of the welfare system who require the data to verify an individual's identity; determine eligibility, amount of assistance, and the need to provide services to an individual or family across programs; coordinate services for an individual or family; evaluate the effectiveness of programs; assess parental contribution amounts; and investigate suspected fraud;

(6) to administer federal funds or programs;

(7) between personnel of the welfare system working in the same program;

(8) to the Department of Revenue to assess parental contribution amounts for purposes of section 252.27, subdivision 2a, administer and evaluate tax refund or tax credit programs and to identify individuals who may benefit from these programs. The following information may be disclosed under this paragraph: an individual's and their dependent's names, dates of birth, Social Security numbers, income, addresses, and other data as required, upon

request by the Department of Revenue. Disclosures by the commissioner of revenue to the commissioner of human services for the purposes described in this clause are governed by section 270B.14, subdivision 1. Tax refund or tax credit programs include, but are not limited to, the dependent care credit under section 290.067, the Minnesota working family credit under section 290.0671, the property tax refund and rental credit under section 290A.04, and the Minnesota education credit under section 290.0674;

(9) between the Department of Human Services, the Department of Employment and Economic Development, and when applicable, the Department of Education, for the following purposes:

(i) to monitor the eligibility of the data subject for unemployment benefits, for any employment or training program administered, supervised, or certified by that agency;

(ii) to administer any rehabilitation program or child care assistance program, whether alone or in conjunction with the welfare system;

(iii) to monitor and evaluate the Minnesota family investment program or the child care assistance program by exchanging data on recipients and former recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, medical programs under chapter 256B or 256L, or a medical program formerly codified under chapter 256D; and

(iv) to analyze public assistance employment services and program utilization, cost, effectiveness, and outcomes as implemented under the authority established in Title II, Sections 201-204 of the Ticket to Work and Work Incentives Improvement Act of 1999. Health records governed by sections 144.291 to 144.298 and "protected health information" as defined in Code of Federal Regulations, title 45, section 160.103, and governed by Code of Federal Regulations, title 45, parts 160-164, including health care claims utilization information, must not be exchanged under this clause;

(10) to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the individual or other individuals or persons;

(11) data maintained by residential programs as defined in section 245A.02 may be disclosed to the protection and advocacy system established in this state according to Part C of Public Law 98-527 to protect the legal and human rights of persons with developmental disabilities or other related conditions who live in residential facilities for these persons if the protection and advocacy system receives a complaint by or on behalf of that person and

the person does not have a legal guardian or the state or a designee of the state is the legal guardian of the person;

(12) to the county medical examiner or the county coroner for identifying or locating relatives or friends of a deceased person;

(13) data on a child support obligor who makes payments to the public agency may be disclosed to the Minnesota Office of Higher Education to the extent necessary to determine eligibility under section 136A.121, subdivision 2, clause (5);

(14) participant Social Security numbers and names collected by the telephone assistance program may be disclosed to the Department of Revenue to conduct an electronic data match with the property tax refund database to determine eligibility under section 237.70, subdivision 4a;

(15) the current address of a Minnesota family investment program participant may be disclosed to law enforcement officers who provide the name of the participant and notify the agency that:

(i) the participant:

(A) is a fugitive felon fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony under the laws of the jurisdiction from which the individual is fleeing; or

(B) is violating a condition of probation or parole imposed under state or federal law;

(ii) the location or apprehension of the felon is within the law enforcement officer's official duties; and

(iii) the request is made in writing and in the proper exercise of those duties;

(16) the current address of a recipient of general assistance may be disclosed to probation officers and corrections agents who are supervising the recipient and to law enforcement officers who are investigating the recipient in connection with a felony level offense;

(17) information obtained from food support applicant or recipient households may be disclosed to local, state, or federal law enforcement officials, upon their written request, for the purpose of investigating an alleged violation of the Food Stamp Act, according to Code of Federal Regulations, title 7, section 272.1(c);

(18) the address, Social Security number, and, if available, photograph of any member of a household receiving food support shall be made available, on request, to a local, state,

or federal law enforcement officer if the officer furnishes the agency with the name of the member and notifies the agency that:

(i) the member:

(A) is fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony in the jurisdiction the member is fleeing;

(B) is violating a condition of probation or parole imposed under state or federal law; or

(C) has information that is necessary for the officer to conduct an official duty related to conduct described in subitem (A) or (B);

(ii) locating or apprehending the member is within the officer's official duties; and

(iii) the request is made in writing and in the proper exercise of the officer's official duty;

(19) the current address of a recipient of Minnesota family investment program, general assistance, or food support may be disclosed to law enforcement officers who, in writing, provide the name of the recipient and notify the agency that the recipient is a person required to register under section 243.166, but is not residing at the address at which the recipient is registered under section 243.166;

(20) certain information regarding child support obligors who are in arrears may be made public according to section 518A.74;

(21) data on child support payments made by a child support obligor and data on the distribution of those payments excluding identifying information on obligees may be disclosed to all obligees to whom the obligor owes support, and data on the enforcement actions undertaken by the public authority, the status of those actions, and data on the income of the obligor or obligee may be disclosed to the other party;

(22) data in the work reporting system may be disclosed under section 256.998, subdivision 7;

(23) to the Department of Education for the purpose of matching Department of Education student data with public assistance data to determine students eligible for free and reduced-price meals, meal supplements, and free milk according to United States Code, title 42, sections 1758, 1761, 1766, 1766a, 1772, and 1773; to allocate federal and state funds that are distributed based on income of the student's family; and to verify receipt of energy assistance for the telephone assistance plan;

(24) the current address and telephone number of program recipients and emergency contacts may be released to the commissioner of health or a community health board as defined in section 145A.02, subdivision 5, when the commissioner or community health board has reason to believe that a program recipient is a disease case, carrier, suspect case, or at risk of illness, and the data are necessary to locate the person;

(25) to other state agencies, statewide systems, and political subdivisions of this state, including the attorney general, and agencies of other states, interstate information networks, federal agencies, and other entities as required by federal regulation or law for the administration of the child support enforcement program;

(26) to personnel of public assistance programs as defined in section 256.741, for access to the child support system database for the purpose of administration, including monitoring and evaluation of those public assistance programs;

(27) to monitor and evaluate the Minnesota family investment program by exchanging data between the Departments of Human Services and Education, on recipients and former recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, medical programs under chapter 256B or 256L, or a medical program formerly codified under chapter 256D;

(28) to evaluate child support program performance and to identify and prevent fraud in the child support program by exchanging data between the Department of Human Services, Department of Revenue under section 270B.14, subdivision 1, paragraphs (a) and (b), without regard to the limitation of use in paragraph (c), Department of Health, Department of Employment and Economic Development, and other state agencies as is reasonably necessary to perform these functions;

(29) counties and the Department of Human Services operating child care assistance programs under chapter 119B may disseminate data on program participants, applicants, and providers to the commissioner of education;

(30) child support data on the child, the parents, and relatives of the child may be disclosed to agencies administering programs under titles IV-B and IV-E of the Social Security Act, as authorized by federal law;

(31) to a health care provider governed by sections 144.291 to 144.298, to the extent necessary to coordinate services;

(32) to the chief administrative officer of a school to coordinate services for a student and family; data that may be disclosed under this clause are limited to name, date of birth, gender, and address; or

(33) to county correctional agencies to the extent necessary to coordinate services and diversion programs; data that may be disclosed under this clause are limited to name, client demographics, program, case status, and county worker information.

(b) Information on persons who have been treated for drug or alcohol abuse may only be disclosed according to the requirements of Code of Federal Regulations, title 42, sections 2.1 to 2.67.

(c) Data provided to law enforcement agencies under paragraph (a), clause (15), (16), (17), or (18), or paragraph (b), are investigative data and are confidential or protected nonpublic while the investigation is active. The data are private after the investigation becomes inactive under section 13.82, subdivision 5, paragraph (a) or (b).

(d) Mental health data shall be treated as provided in subdivisions 7, 8, and 9, but are not subject to the access provisions of subdivision 10, paragraph (b).

For the purposes of this subdivision, a request will be deemed to be made in writing if made through a computer interface system.

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

Sec. 2. Minnesota Statutes 2018, section 13.46, subdivision 3, is amended to read:

Subd. 3. **Investigative data.** (a) Data on persons, including data on vendors of services, licensees, and applicants that is collected, maintained, used, or disseminated by the welfare system in an investigation, authorized by statute, and relating to the enforcement of rules or law are confidential data on individuals pursuant to section 13.02, subdivision 3, or protected nonpublic data not on individuals pursuant to section 13.02, subdivision 13, and shall not be disclosed except:

(1) pursuant to section 13.05;

(2) pursuant to statute or valid court order;

(3) to a party named in a civil or criminal proceeding, administrative or judicial, for preparation of defense; ~~or~~

(4) to an agent of the welfare system or an investigator acting on behalf of a county, state, or federal government, including a law enforcement officer or attorney in the investigation or prosecution of a criminal, civil, or administrative proceeding, unless the

commissioner of human services determines that disclosure may compromise a Department of Human Services ongoing investigation; or

~~(4)~~ (5) to provide notices required or permitted by statute.

The data referred to in this subdivision shall be classified as public data upon submission to an administrative law judge or court in an administrative or judicial proceeding. Inactive welfare investigative data shall be treated as provided in section 13.39, subdivision 3.

(b) Notwithstanding any other provision in law, the commissioner of human services shall provide all active and inactive investigative data, including the name of the reporter of alleged maltreatment under section 626.556 or 626.557, to the ombudsman for mental health and developmental disabilities upon the request of the ombudsman.

(c) Notwithstanding paragraph (a) and section 13.39, the existence of an investigation by the commissioner of human services of possible overpayments of public funds to a service provider or recipient may be disclosed if the commissioner determines that it will not compromise the investigation.

Sec. 3. Minnesota Statutes 2018, section 13.461, subdivision 28, is amended to read:

Subd. 28. **Child care assistance program.** Data collected, maintained, used, or disseminated by the welfare system pertaining to persons selected as legal nonlicensed child care providers by families receiving child care assistance are classified under section 119B.02, subdivision 6, paragraph (a). Child care assistance program payment data is classified under section 119B.02, subdivision 6, paragraph (b).

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

Sec. 4. Minnesota Statutes 2018, section 15C.02, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 5. Minnesota Statutes 2018, section 119B.02, subdivision 6, is amended to read:

Subd. 6. **Data.** (a) Data collected, maintained, used, or disseminated by the welfare system pertaining to persons selected as legal nonlicensed child care providers by families receiving child care assistance shall be treated as licensing data as provided in section 13.46, subdivision 4.

(b) For purposes of this paragraph, "child care assistance program payment data" means data for a specified time period showing (1) that a child care assistance program payment under this chapter was made, and (2) the amount of child care assistance payments made to a child care center. Child care assistance program payment data may include the number of families and children on whose behalf payments were made for the specified time period. Any child care assistance program payment data that may identify a specific child care assistance recipient or benefit paid on behalf of a specific child care assistance recipient, as determined by the commissioner, is private data on individuals as defined in section 13.02, subdivision 12. Data related to a child care assistance payment is public if the data relates to a child care assistance payment made to a licensed child care center or a child care center exempt from licensure and:

(1) the child care center receives payment of more than $100,000 from the child care assistance program under this chapter in a period of one year or less; or

(2) when the commissioner or county agency either:

(i) disqualified the center from receipt of a payment from the child care assistance program under this chapter for wrongfully obtaining child care assistance under section 256.98, subdivision 8, paragraph (c);

(ii) refused a child care authorization, revoked a child care authorization, stopped payment, or denied payment for a bill for the center under section 119B.13, subdivision 6, paragraph (d); or

(iii) made a finding of financial misconduct under section 245E.02.

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

Sec. 6. Minnesota Statutes 2018, section 119B.09, subdivision 7, is amended to read:

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

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

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

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

Sec. 7. Minnesota Statutes 2018, section 119B.125, subdivision 6, is amended to read:

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

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

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

~~The~~ (b) As a condition of payment, attendance records must be completed daily and include the date, the first and last name of each child in attendance, and the times when each child is dropped off and picked up. To the extent possible, the times that the child was dropped off to and picked up from the child care provider must be entered by the person

dropping off or picking up the child. The daily attendance records must be retained at the site where services are delivered for six years after the date of service.

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

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

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

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

Sec. 8. Minnesota Statutes 2018, section 119B.13, subdivision 6, is amended to read:

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

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

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

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

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

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

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

(4) the provider is operating after:

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

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

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

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

(6) the provider gives false child care price information~~.~~<u>; or</u>

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

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

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

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

Sec. 9. Minnesota Statutes 2018, section 119B.13, subdivision 7, is amended to read:

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

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

(c) Notwithstanding paragraph (a), children in families may exceed the absent days limit if at least one parent: (1) is under the age of 21; (2) does not have a high school diploma or commissioner of education-selected high school equivalency certification; and (3) is a student in a school district or another similar program that provides or arranges for child care, parenting support, social services, career and employment supports, and academic support to achieve high school graduation, upon request of the program and approval of the county. If a child attends part of an authorized day, payment to the provider must be for the full amount of care authorized for that day.

(d) Child care providers must be reimbursed for up to ten federal or state holidays or designated holidays per year when the provider charges all families for these days and the holiday or designated holiday falls on a day when the child is authorized to be in attendance.

Parents may substitute other cultural or religious holidays for the ten recognized state and federal holidays. Holidays do not count toward the absent days limit.

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

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

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

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

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

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

Sec. 10. Minnesota Statutes 2018, section 144.057, subdivision 3, is amended to read:

Subd. 3. **Reconsiderations.** The commissioner of health shall review and decide reconsideration requests, including the granting of variances, in accordance with the procedures and criteria contained in chapter 245C. The commissioner must set aside a disqualification for an individual who requests reconsideration and who meets the criteria described in section 245C.22, subdivision 4, paragraph (d). The commissioner's decision shall be provided to the individual and to the Department of Human Services. The commissioner's decision to grant or deny a reconsideration of disqualification is the final administrative agency action, except for the provisions under sections 245C.25, 245C.27, and 245C.28, subdivision 3.

Sec. 11. Minnesota Statutes 2018, section 245.095, is amended to read:

**245.095 LIMITS ON RECEIVING PUBLIC FUNDS.**

Subdivision 1. **Prohibition.** (a) If a provider, vendor, or individual enrolled, licensed, ~~or~~ receiving funds under a grant contract, or registered in any program administered by the commissioner, including under the commissioner's powers and authorities in section 256.01, is excluded from ~~any~~ that program ~~administered by the commissioner, including under the commissioner's powers and authorities in section 256.01~~, the commissioner shall:

(1) prohibit the excluded provider, vendor, or individual from enrolling ~~or~~, becoming licensed, receiving grant funds, or registering in any other program administered by the commissioner~~.~~; and

(2) disenroll, revoke or suspend a license, disqualify, or debar the excluded provider, vendor, or individual in any other program administered by the commissioner.

(b) The duration of this prohibition, disenrollment, revocation, suspension, disqualification, or debarment must last for the longest applicable sanction or disqualifying period in effect for the provider, vendor, or individual permitted by state or federal law.

Subd. 2. **Definitions.** (a) For purposes of this section, the following definitions have the meanings given them.

(b) "Excluded" means disenrolled, ~~subject to license revocation or suspension, disqualified, or subject to vendor debarment~~ disqualified, having a license that has been revoked or suspended under chapter 245A, or debarred or suspended under Minnesota Rules, part 1230.1150, or excluded pursuant to section 256B.064, subdivision 3.

(c) "Individual" means a natural person providing products or services as a provider or vendor.

(d) "Provider" ~~means~~ includes any entity or individual receiving payment from a program administered by the Department of Human Services, and an owner, controlling individual, license holder, director, or managerial official of an entity receiving payment from a program administered by the Department of Human Services.

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

Sec. 12. Minnesota Statutes 2018, section 245A.02, subdivision 3, is amended to read:

Subd. 3. **Applicant.** "Applicant" means an individual, ~~corporation, partnership, voluntary association, controlling individual, or other~~ organization, or government entity, as defined in section 13.02, subdivision 7a, that ~~has applied for licensure under this chapter and the~~

~~rules of the commissioner~~ is subject to licensure under this chapter and that has applied for but not yet been granted a license under this chapter.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 13. Minnesota Statutes 2018, section 245A.02, is amended by adding a subdivision to read:

Subd. 3b. **Authorized agent.** "Authorized agent" means the controlling individual designated by the license holder responsible for communicating with the commissioner of human services on all matters related to this chapter and on whom service of all notices and orders must be made pursuant to section 245A.04, subdivision 1.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 14. Minnesota Statutes 2018, section 245A.02, subdivision 8, is amended to read:

Subd. 8. **License.** "License" means a certificate issued by the commissioner under section 245A.04 authorizing the license holder to provide a specified program for a specified period of time and in accordance with the terms of the license and the rules of the commissioner.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 15. Minnesota Statutes 2018, section 245A.02, subdivision 9, is amended to read:

Subd. 9. **License holder.** "License holder" means an individual, ~~corporation, partnership, voluntary association, or other~~ organization, or government entity that is legally responsible for the operation of the program or service, and has been granted a license by the commissioner under this chapter ~~or chapter 245D~~ and the rules of the commissioner~~, and is a controlling individual~~.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 16. Minnesota Statutes 2018, section 245A.02, is amended by adding a subdivision to read:

Subd. 10c. **Organization.** "Organization" means a domestic or foreign corporation, nonprofit corporation, limited liability company, partnership, limited partnership, limited liability partnership, association, voluntary association, and any other legal or commercial entity. For purposes of this chapter, organization does not include a government entity.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 17. Minnesota Statutes 2018, section 245A.02, subdivision 12, is amended to read:

Subd. 12. **Private agency.** "Private agency" means an ~~individual, corporation, partnership, voluntary association or other~~ organization, other than a county agency, or a court with jurisdiction, that places persons who cannot remain in their own homes in residential programs, foster care, or adoptive homes.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 18. Minnesota Statutes 2018, section 245A.02, subdivision 14, is amended to read:

Subd. 14. **Residential program.** (a) Except as provided in paragraph (b), "residential program" means a program that provides 24-hour-a-day care, supervision, food, lodging, rehabilitation, training, education, habilitation, or treatment outside a person's own home, including a program in an intermediate care facility for four or more persons with developmental disabilities; and chemical dependency or chemical abuse programs that are located in a hospital or nursing home and receive public funds for providing chemical abuse or chemical dependency treatment services under chapter 254B. ~~Residential programs include home and community-based services for persons with disabilities or persons age 65 and older that are provided in or outside of a person's own home under chapter 245D.~~

(b) For a residential program under chapter 245D, "residential program" means a single or multifamily dwelling that is under the control, either directly or indirectly, of the service provider licensed under chapter 245D and in which at least one person receives services under chapter 245D, including residential supports and services under section 245D.03, subdivision 1, paragraph (c), clause (3); out-of-home crisis respite services under section 245D.03, subdivision 1, paragraph (c), clause (1), item (ii); and out-of-home respite services under section 245D.03, subdivision 1, paragraph (b), clause (1). A residential program does not include out-of-home respite services when a case manager has determined that an unlicensed site meets the assessed needs of the person. A residential program also does not include multifamily dwellings where persons receive integrated community supports, even if authorization to provide these supports is granted under chapter 245D and approved in the federal waiver.

Sec. 19. Minnesota Statutes 2018, section 245A.02, subdivision 18, is amended to read:

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

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

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

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

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

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

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

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

Sec. 20. Minnesota Statutes 2018, section 245A.03, subdivision 1, is amended to read:

Subdivision 1. **License required.** Unless licensed by the commissioner under this chapter, an individual, ~~corporation, partnership, voluntary association, other~~ organization, or ~~controlling individual~~ government entity must not:

(1) operate a residential or a nonresidential program;

(2) receive a child or adult for care, supervision, or placement in foster care or adoption;

(3) help plan the placement of a child or adult in foster care or adoption or engage in placement activities as defined in section 259.21, subdivision 9, in this state, whether or not the adoption occurs in this state; or

(4) advertise a residential or nonresidential program.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 21. Minnesota Statutes 2018, section 245A.03, subdivision 3, is amended to read:

Subd. 3. **Unlicensed programs.** (a) It is a misdemeanor for an individual, ~~corporation, partnership, voluntary association, other~~ organization, or ~~a controlling individual~~ government entity to provide a residential or nonresidential program without a license issued under this chapter and in willful disregard of this chapter unless the program is excluded from licensure under subdivision 2.

(b) The commissioner may ask the appropriate county attorney or the attorney general to begin proceedings to secure a court order against the continued operation of the program, if an individual, ~~corporation, partnership, voluntary association, other~~ organization, or ~~controlling individual~~ government entity has:

(1) failed to apply for a license under this chapter after receiving notice that a license is required or continues to operate without a license after receiving notice that a license is required;

(2) continued to operate without a license after ~~the~~ a license issued under this chapter has been revoked or suspended under ~~section 245A.07~~ this chapter, and the commissioner has issued a final order affirming the revocation or suspension, or the license holder did not timely appeal the sanction; or

(3) continued to operate without a license after ~~the~~ a temporary immediate suspension of a license has been ~~temporarily suspended under section 245A.07~~ issued under this chapter.

(c) The county attorney and the attorney general have a duty to cooperate with the commissioner.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 22. Minnesota Statutes 2018, section 245A.04, subdivision 1, is amended to read:

Subdivision 1. **Application for licensure.** (a) An individual, ~~corporation, partnership, voluntary association, other~~ organization ~~or controlling individual~~, or government entity that is subject to licensure under section 245A.03 must apply for a license. The application must be made on the forms and in the manner prescribed by the commissioner. The commissioner shall provide the applicant with instruction in completing the application and provide information about the rules and requirements of other state agencies that affect the applicant. An applicant seeking licensure in Minnesota with headquarters outside of Minnesota must have a program office located within 30 miles of the ~~state~~ Minnesota border. An applicant who intends to buy or otherwise acquire a program or services licensed under

this chapter that is owned by another license holder must apply for a license under this chapter and comply with the application procedures in this section and section 245A.03.

The commissioner shall act on the application within 90 working days after a complete application and any required reports have been received from other state agencies or departments, counties, municipalities, or other political subdivisions. The commissioner shall not consider an application to be complete until the commissioner receives all of the ~~information~~ required ~~under section 245C.05~~ information.

When the commissioner receives an application for initial licensure that is incomplete because the applicant failed to submit required documents or that is substantially deficient because the documents submitted do not meet licensing requirements, the commissioner shall provide the applicant written notice that the application is incomplete or substantially deficient. In the written notice to the applicant the commissioner shall identify documents that are missing or deficient and give the applicant 45 days to resubmit a second application that is substantially complete. An applicant's failure to submit a substantially complete application after receiving notice from the commissioner is a basis for license denial under section 245A.05.

(b) An application for licensure must identify all controlling individuals as defined in section 245A.02, subdivision 5a, and must ~~specify an~~ designate one individual to be the authorized agent ~~who is responsible for dealing with the commissioner of human services on all matters provided for in this chapter and on whom service of all notices and orders must be made~~. The application must be signed by the authorized agent and must include the authorized agent's first, middle, and last name; mailing address; and e-mail address. By submitting an application for licensure, the authorized agent consents to electronic communication with the commissioner throughout the application process. The authorized agent must be authorized to accept service on behalf of all of the controlling individuals ~~of the program~~. A government entity that holds multiple licenses under this chapter may designate one authorized agent for all licenses issued under this chapter or may designate a different authorized agent for each license. Service on the authorized agent is service on all of the controlling individuals ~~of the program~~. It is not a defense to any action arising under this chapter that service was not made on each controlling individual ~~of the program~~. The designation of ~~one or more~~ a controlling ~~individuals~~ individual as ~~agents~~ the authorized agent under this paragraph does not affect the legal responsibility of any other controlling individual under this chapter.

(c) An applicant or license holder must have a policy that prohibits license holders, employees, subcontractors, and volunteers, when directly responsible for persons served

by the program, from abusing prescription medication or being in any manner under the influence of a chemical that impairs the individual's ability to provide services or care. The license holder must train employees, subcontractors, and volunteers about the program's drug and alcohol policy.

(d) An applicant and license holder must have a program grievance procedure that permits persons served by the program and their authorized representatives to bring a grievance to the highest level of authority in the program.

(e) ~~The applicant must be able to demonstrate competent knowledge of the applicable requirements of this chapter and chapter 245C, and the requirements of other licensing statutes and rules applicable to the program or services for which the applicant is seeking to be licensed. Effective January 1, 2013,~~ The commissioner may limit communication during the application process to the authorized agent or the controlling individuals identified on the license application and for whom a background study was initiated under chapter 245C. The commissioner may require the applicant, except for child foster care, to demonstrate competence in the applicable licensing requirements by successfully completing a written examination. The commissioner may develop a prescribed written examination format.

(f) When an applicant is an individual, the ~~individual~~ applicant must provide:

(1) the applicant's taxpayer identification numbers including the Social Security number or Minnesota tax identification number, and federal employer identification number if the applicant has employees;

(2) at the request of the commissioner, a copy of the most recent filing with the secretary of state that includes the complete business name, if any~~, and~~;

(3) if doing business under a different name, the doing business as (DBA) name, as registered with the secretary of state; ~~and~~

~~(3) a notarized signature of the applicant.~~ (4) if applicable, the applicant's National Provider Identifier (NPI) number and Unique Minnesota Provider Identifier (UMPI) number; and

(5) at the request of the commissioner, the notarized signature of the applicant or authorized agent.

(g) When an applicant is ~~a nonindividual~~ an organization, the applicant must provide ~~the~~:

(1) the applicant's taxpayer identification numbers including the Minnesota tax identification number and federal employer identification number;

(2) at the request of the commissioner, a copy of the most recent filing with the secretary of state that includes the complete business name, and if doing business under a different name, the doing business as (DBA) name, as registered with the secretary of state;

(3) the first, middle, and last name, and address for all individuals who will be controlling individuals, including all officers, owners, and managerial officials as defined in section 245A.02, subdivision 5a, and the date that the background study was initiated by the applicant for each controlling individual; ~~and~~

~~(4) first, middle, and last name, mailing address, and notarized signature of the agent authorized by the applicant to accept service on behalf of the controlling individuals.~~

(4) if applicable, the applicant's NPI number and UMPI number;

(5) the documents that created the organization and that determine the organization's internal governance and the relations among the persons that own the organization, have an interest in the organization, or are members of the organization, in each case as provided or authorized by the organization's governing statute, which may include a partnership agreement, bylaws, articles of organization, organizational chart, and operating agreement, or comparable documents as provided in the organization's governing statute; and

(6) the notarized signature of the applicant or authorized agent.

(h) When the applicant is a government entity, the applicant must provide:

(1) the name of the government agency, political subdivision, or other unit of government seeking the license and the name of the program or services that will be licensed;

(2) the applicant's taxpayer identification numbers including the Minnesota tax identification number and federal employer identification number;

(3) a letter signed by the manager, administrator, or other executive of the government entity authorizing the submission of the license application; and

(4) if applicable, the applicant's NPI number and UMPI number.

~~(h)~~ (i) At the time of application for licensure or renewal of a license under this chapter, the applicant or license holder must acknowledge on the form provided by the commissioner if the applicant or license holder elects to receive any public funding reimbursement from the commissioner for services provided under the license that:

(1) the applicant's or license holder's compliance with the provider enrollment agreement or registration requirements for receipt of public funding may be monitored by the commissioner as part of a licensing investigation or licensing inspection; and

(2) noncompliance with the provider enrollment agreement or registration requirements for receipt of public funding that is identified through a licensing investigation or licensing inspection, or noncompliance with a licensing requirement that is a basis of enrollment for reimbursement for a service, may result in:

(i) a correction order or a conditional license under section 245A.06, or sanctions under section 245A.07;

(ii) nonpayment of claims submitted by the license holder for public program reimbursement;

(iii) recovery of payments made for the service;

(iv) disenrollment in the public payment program; or

(v) other administrative, civil, or criminal penalties as provided by law.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 23. Minnesota Statutes 2018, section 245A.04, subdivision 2, is amended to read:

Subd. 2. **Notification of affected municipality.** The commissioner must not issue a license under this chapter without giving 30 calendar days' written notice to the affected municipality or other political subdivision unless the program is considered a permitted single-family residential use under sections 245A.11 and 245A.14. The commissioner may provide notice through electronic communication. The notification must be given before the first issuance of a license under this chapter and annually after that time if annual notification is requested in writing by the affected municipality or other political subdivision. State funds must not be made available to or be spent by an agency or department of state, county, or municipal government for payment to a residential or nonresidential program licensed under this chapter until the provisions of this subdivision have been complied with in full. The provisions of this subdivision shall not apply to programs located in hospitals.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 24. Minnesota Statutes 2018, section 245A.04, subdivision 4, is amended to read:

Subd. 4. **Inspections; waiver.** (a) Before issuing ~~an initial~~ a license under this chapter, the commissioner shall conduct an inspection of the program. The inspection must include but is not limited to:

(1) an inspection of the physical plant;

(2) an inspection of records and documents;

~~(3) an evaluation of the program by consumers of the program;~~

~~(4)~~ (3) observation of the program in operation; and

~~(5)~~ (4) an inspection for the health, safety, and fire standards in licensing requirements for a child care license holder.

~~For the purposes of this subdivision, "consumer" means a person who receives the services of a licensed program, the person's legal guardian, or the parent or individual having legal custody of a child who receives the services of a licensed program.~~

(b) The ~~evaluation required in paragraph (a), clause (3), or the~~ observation in paragraph (a), clause ~~(4)~~ (3), is not required prior to issuing ~~an initial~~ a license under subdivision 7. If the commissioner issues ~~an initial~~ a license under ~~subdivision 7~~ this chapter, these requirements must be completed within one year after the issuance of ~~an initial~~ the license.

(c) Before completing a licensing inspection in a family child care program or child care center, the licensing agency must offer the license holder an exit interview to discuss violations or potential violations of law or rule observed during the inspection and offer technical assistance on how to comply with applicable laws and rules. ~~Nothing in this paragraph limits the ability of the commissioner to issue a correction order or negative action for violations of law or rule not discussed in an exit interview or in the event that a license holder chooses not to participate in an exit interview.~~ The commissioner shall not issue a correction order or negative licensing action for violations of law or rule not discussed in an exit interview, unless a license holder chooses not to participate in an exit interview or not to complete the exit interview. If the license holder is unable to complete the exit interview, the licensing agency must offer an alternate time for the license holder to complete the exit interview.

(d) If a family child care license holder disputes a county licensor's interpretation of a licensing requirement during a licensing inspection or exit interview, the license holder may, within five business days after the exit interview or licensing inspection, request clarification from the commissioner, in writing, in a manner prescribed by the commissioner.

The license holder's request must describe the county licensor's interpretation of the licensing requirement at issue, and explain why the license holder believes the county licensor's interpretation is inaccurate. The commissioner and the county must include the license holder in all correspondence regarding the disputed interpretation, and must provide an opportunity for the license holder to contribute relevant information that may impact the commissioner's decision. The county licensor must not issue a correction order related to the disputed licensing requirement until the commissioner has provided clarification to the license holder about the licensing requirement.

~~(d)~~ (e) The commissioner or the county shall inspect at least annually a child care provider licensed under this chapter and Minnesota Rules, chapter 9502 or 9503, for compliance with applicable licensing standards.

~~(e)~~ (f) No later than November 19, 2017, the commissioner shall make publicly available on the department's website the results of inspection reports of all child care providers licensed under this chapter and under Minnesota Rules, chapter 9502 or 9503, and the number of deaths, serious injuries, and instances of substantiated child maltreatment that occurred in licensed child care settings each year.

**EFFECTIVE DATE.** The amendments to paragraphs (a) and (b) are effective January 1, 2020. The amendments to paragraphs (c) to (f) are effective September 30, 2019.

Sec. 25. Minnesota Statutes 2018, section 245A.04, subdivision 6, is amended to read:

Subd. 6. **Commissioner's evaluation.** (a) Before issuing, denying, suspending, revoking, or making conditional a license, the commissioner shall evaluate information gathered under this section. The commissioner's evaluation shall consider the applicable requirements of statutes and rules for the program or services for which the applicant seeks a license, including the disqualification standards set forth in chapter 245C, and shall evaluate facts, conditions, or circumstances concerning:

(1) the program's operation~~,~~;

(2) the well-being of persons served by the program~~,~~;

(3) available ~~consumer~~ evaluations of the program~~, and~~ by persons receiving services;

(4) information about the qualifications of the personnel employed by the applicant or license holder~~.~~; and

(5) the applicant's or license holder's ability to demonstrate competent knowledge of the applicable requirements of statutes and rules, including this chapter and chapter 245C, for which the applicant seeks a license or the license holder is licensed.

(b) The commissioner shall also evaluate the results of the study required in subdivision 3 and determine whether a risk of harm to the persons served by the program exists. In conducting this evaluation, the commissioner shall apply the disqualification standards set forth in chapter 245C.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 26. Minnesota Statutes 2018, section 245A.04, subdivision 7, is amended to read:

Subd. 7. **Grant of license; license extension.** (a) If the commissioner determines that the program complies with all applicable rules and laws, the commissioner shall issue a license consistent with this section or, if applicable, a temporary change of ownership license under section 245A.043. At minimum, the license shall state:

(1) the name of the license holder;

(2) the address of the program;

(3) the effective date and expiration date of the license;

(4) the type of license;

(5) the maximum number and ages of persons that may receive services from the program; and

(6) any special conditions of licensure.

(b) The commissioner may issue ~~an initial~~ a license for a period not to exceed two years if:

(1) the commissioner is unable to conduct the evaluation or observation required by subdivision 4, paragraph (a), ~~clauses (3) and~~ clause (4), because the program is not yet operational;

(2) certain records and documents are not available because persons are not yet receiving services from the program; and

(3) the applicant complies with applicable laws and rules in all other respects.

(c) A decision by the commissioner to issue a license does not guarantee that any person or persons will be placed or cared for in the licensed program. ~~A license shall not be~~

~~transferable to another individual, corporation, partnership, voluntary association, other organization, or controlling individual or to another location.~~

~~(d) A license holder must notify the commissioner and obtain the commissioner's approval before making any changes that would alter the license information listed under paragraph (a).~~

~~(e)~~ (d) Except as provided in paragraphs ~~(g)~~ (f) and ~~(h)~~ (g), the commissioner shall not issue or reissue a license if the applicant, license holder, or controlling individual has:

(1) been disqualified and the disqualification was not set aside and no variance has been granted;

(2) been denied a license under this chapter, within the past two years;

(3) had a license issued under this chapter revoked within the past five years;

(4) an outstanding debt related to a license fee, licensing fine, or settlement agreement for which payment is delinquent; or

(5) failed to submit the information required of an applicant under subdivision 1, paragraph (f) or (g), after being requested by the commissioner.

When a license issued under this chapter is revoked under clause (1) or (3), the license holder and controlling individual may not hold any license under chapter 245A ~~or 245D~~ for five years following the revocation, and other licenses held by the applicant, license holder, or controlling individual shall also be revoked.

~~(f)~~ (e) The commissioner shall not issue or reissue a license under this chapter if an individual living in the household where the ~~licensed~~ services will be provided as specified under section 245C.03, subdivision 1, has been disqualified and the disqualification has not been set aside and no variance has been granted.

~~(g)~~ (f) Pursuant to section 245A.07, subdivision 1, paragraph (b), when a license issued under this chapter has been suspended or revoked and the suspension or revocation is under appeal, the program may continue to operate pending a final order from the commissioner. If the license under suspension or revocation will expire before a final order is issued, a temporary provisional license may be issued provided any applicable license fee is paid before the temporary provisional license is issued.

~~(h)~~ (g) Notwithstanding paragraph ~~(g)~~ (f), when a revocation is based on the disqualification of a controlling individual or license holder, and the controlling individual or license holder is ordered under section 245C.17 to be immediately removed from direct

contact with persons receiving services or is ordered to be under continuous, direct supervision when providing direct contact services, the program may continue to operate only if the program complies with the order and submits documentation demonstrating compliance with the order. If the disqualified individual fails to submit a timely request for reconsideration, or if the disqualification is not set aside and no variance is granted, the order to immediately remove the individual from direct contact or to be under continuous, direct supervision remains in effect pending the outcome of a hearing and final order from the commissioner.

~~(i)~~ (h) For purposes of reimbursement for meals only, under the Child and Adult Care Food Program, Code of Federal Regulations, title 7, subtitle B, chapter II, subchapter A, part 226, relocation within the same county by a licensed family day care provider, shall be considered an extension of the license for a period of no more than 30 calendar days or until the new license is issued, whichever occurs first, provided the county agency has determined the family day care provider meets licensure requirements at the new location.

~~(j)~~ (i) Unless otherwise specified by statute, all licenses issued under this chapter expire at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must apply for and be granted a new license to operate the program or the program must not be operated after the expiration date.

~~(k)~~ (j) The commissioner shall not issue or reissue a license under this chapter if it has been determined that a tribal licensing authority has established jurisdiction to license the program or service.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 27. Minnesota Statutes 2018, section 245A.04, is amended by adding a subdivision to read:

Subd. 7a. **Notification required.** (a) A license holder must notify the commissioner, in a manner prescribed by the commissioner, and obtain the commissioner's approval before making any change that would alter the license information listed under subdivision 7, paragraph (a).

(b) A license holder must also notify the commissioner, in a manner prescribed by the commissioner, before making any change:

(1) to the license holder's authorized agent as defined in section 245A.02, subdivision 3b;

(2) to the license holder's controlling individual as defined in section 245A.02, subdivision 5a;

(3) to the license holder information on file with the secretary of state;

(4) in the location of the program or service licensed under this chapter; and

(5) to the federal or state tax identification number associated with the license holder.

(c) When, for reasons beyond the license holder's control, a license holder cannot provide the commissioner with prior notice of the changes in paragraph (b), clauses (1) to (3), the license holder must notify the commissioner by the tenth business day after the change and must provide any additional information requested by the commissioner.

(d) When a license holder notifies the commissioner of a change to the license holder information on file with the secretary of state, the license holder must provide amended articles of incorporation and other documentation of the change.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 28. Minnesota Statutes 2018, section 245A.04, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

Sec. 29. Minnesota Statutes 2018, section 245A.04, subdivision 10, is amended to read:

Subd. 10. **Adoption agency; additional requirements.** In addition to the other requirements of this section, an individual~~, corporation, partnership, voluntary association, other~~ or organization~~, or controlling individual~~ applying for a license to place children for adoption must:

(1) incorporate as a nonprofit corporation under chapter 317A;

(2) file with the application for licensure a copy of the disclosure form required under section 259.37, subdivision 2;

(3) provide evidence that a bond has been obtained and will be continuously maintained throughout the entire operating period of the agency, to cover the cost of transfer of records to and storage of records by the agency which has agreed, according to rule established by the commissioner, to receive the applicant agency's records if the applicant agency voluntarily or involuntarily ceases operation and fails to provide for proper transfer of the records. The bond must be made in favor of the agency which has agreed to receive the records; and

(4) submit a certified audit to the commissioner each year the license is renewed as required under section 245A.03, subdivision 1.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 30. **[245A.043] LICENSE APPLICATION AFTER CHANGE OF OWNERSHIP.**

Subdivision 1. **Transfer prohibited.** A license issued under this chapter is only valid for a premises and individual, organization, or government entity identified by the commissioner on the license. A license is not transferable or assignable.

Subd. 2. **Change in ownership.** (a) If the commissioner determines that there is a change in ownership, the commissioner shall require submission of a new license application. This subdivision does not apply to a licensed program or service located in a home where the license holder resides. A change in ownership occurs when:

(1) the license holder sells or transfers 100 percent of the property, stock, or assets;

(2) the license holder merges with another organization;

(3) the license holder consolidates with two or more organizations, resulting in the creation of a new organization;

(4) there is a change to the federal tax identification number associated with the license holder; or

(5) all controlling individuals associated with the original application have changed.

(b) Notwithstanding paragraph (a), clauses (1) and (5), no change in ownership has occurred if at least one controlling individual has been listed as a controlling individual for the license for at least the previous 12 months.

Subd. 3. **Change of ownership process.** (a) When a change in ownership is proposed and the party intends to assume operation without an interruption in service longer than 60 days after acquiring the program or service, the license holder must provide the commissioner with written notice of the proposed change on a form provided by the commissioner at least 60 days before the anticipated date of the change in ownership. For purposes of this subdivision and subdivision 4, "party" means the party that intends to operate the service or program.

(b) The party must submit a license application under this chapter on the form and in the manner prescribed by the commissioner at least 30 days before the change in ownership is complete, and must include documentation to support the upcoming change. The party must comply with background study requirements under chapter 245C and shall pay the application fee required under section 245A.10. A party that intends to assume operation without an interruption in service longer than 60 days after acquiring the program or service is exempt from the requirements of Minnesota Rules, part 9530.6800.

(c) The commissioner may streamline application procedures when the party is an existing license holder under this chapter and is acquiring a program licensed under this chapter or service in the same service class as one or more licensed programs or services the party operates and those licenses are in substantial compliance. For purposes of this subdivision, "substantial compliance" means within the previous 12 months the commissioner did not (1) issue a sanction under section 245A.07 against a license held by the party, or (2) make a license held by the party conditional according to section 245A.06.

(d) Except when a temporary change in ownership license is issued pursuant to subdivision 4, the existing license holder is solely responsible for operating the program according to applicable laws and rules until a license under this chapter is issued to the party.

(e) If a licensing inspection of the program or service was conducted within the previous 12 months and the existing license holder's record demonstrates substantial compliance with the applicable licensing requirements, the commissioner may waive the party's inspection

required by section 245A.04, subdivision 4. The party must submit to the commissioner (1) proof that the premises was inspected by a fire marshal or that the fire marshal deemed an inspection was not warranted, and (2) proof that the premises was inspected for compliance with the building code or no inspection was deemed warranted.

(f) If the party is seeking a license for a program or service that has an outstanding action under section 245A.06 or 245A.07, the party must submit a letter as part of the application process identifying how the party has or will come into full compliance with the licensing requirements.

(g) The commissioner shall evaluate the party's application according to section 245A.04, subdivision 6. If the commissioner determines that the party has remedied or demonstrates the ability to remedy the outstanding actions under section 245A.06 or 245A.07 and has determined that the program otherwise complies with all applicable laws and rules, the commissioner shall issue a license or conditional license under this chapter. The conditional license remains in effect until the commissioner determines that the grounds for the action are corrected or no longer exist.

(h) The commissioner may deny an application as provided in section 245A.05. An applicant whose application was denied by the commissioner may appeal the denial according to section 245A.05.

(i) This subdivision does not apply to a licensed program or service located in a home where the license holder resides.

Subd. 4. **Temporary change in ownership license.** (a) After receiving the party's application pursuant to subdivision 3, upon the written request of the existing license holder and the party, the commissioner may issue a temporary change in ownership license to the party while the commissioner evaluates the party's application. Until a decision is made to grant or deny a license under this chapter, the existing license holder and the party shall both be responsible for operating the program or service according to applicable laws and rules, and the sale or transfer of the existing license holder's ownership interest in the licensed program or service does not terminate the existing license.

(b) The commissioner may issue a temporary change in ownership license when a license holder's death, divorce, or other event affects the ownership of the program and an applicant seeks to assume operation of the program or service to ensure continuity of the program or service while a license application is evaluated.

(c) This subdivision applies to any program or service licensed under this chapter.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 31. Minnesota Statutes 2018, section 245A.05, is amended to read:

**245A.05 DENIAL OF APPLICATION.**

(a) The commissioner may deny a license if an applicant or controlling individual:

(1) fails to submit a substantially complete application after receiving notice from the commissioner under section 245A.04, subdivision 1;

(2) fails to comply with applicable laws or rules;

(3) knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license or during an investigation;

(4) has a disqualification that has not been set aside under section 245C.22 and no variance has been granted;

(5) has an individual living in the household who received a background study under section 245C.03, subdivision 1, paragraph (a), clause (2), who has a disqualification that has not been set aside under section 245C.22, and no variance has been granted;

(6) is associated with an individual who received a background study under section 245C.03, subdivision 1, paragraph (a), clause (6), who may have unsupervised access to children or vulnerable adults, and who has a disqualification that has not been set aside under section 245C.22, and no variance has been granted; ~~or~~

(7) fails to comply with section 245A.04, subdivision 1, paragraph (f) or (g)~~.~~;

(8) fails to demonstrate competent knowledge as required by section 245A.04, subdivision 6;

(9) has a history of noncompliance as a license holder or controlling individual with applicable laws or rules, including but not limited to this chapter and chapters 119B and 245C;

(10) is prohibited from holding a license according to section 245.095; or

(11) for family child foster care, has nondisqualifying background study information, as described in section 245C.05, subdivision 4, that reflects on the individual's ability to safely provide care to foster children.

(b) An applicant whose application has been denied by the commissioner must be given notice of the denial, which must state the reasons for the denial in plain language. Notice

must be given by certified mail or personal service. The notice must state the reasons the application was denied and must inform the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the commissioner in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the notice of denial. If an appeal request is made by personal service, it must be received by the commissioner within 20 calendar days after the applicant received the notice of denial. Section 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

**EFFECTIVE DATE.** This section is effective January 1, 2020, except paragraph (a), clause (11), is effective March 1, 2020.

Sec. 32. **[245A.055] CLOSING A LICENSE.**

Subdivision 1. **Inactive programs.** The commissioner shall close a license if the commissioner determines that a licensed program has not been serving any client for a consecutive period of 12 months or longer. The license holder is not prohibited from reapplying for a license if the license holder's license was closed under this chapter.

Subd. 2. **Reconsideration of closure.** If a license is closed, the commissioner must notify the license holder of closure by certified mail or personal service. If mailed, the notice of closure must be mailed to the last known address of the license holder and must inform the license holder why the license was closed and that the license holder has the right to request reconsideration of the closure. If the license holder believes that the license was closed in error, the license holder may ask the commissioner to reconsider the closure. The license holder's request for reconsideration must be made in writing and must include documentation that the licensed program has served a client in the previous 12 months. The request for reconsideration must be postmarked and sent to the commissioner within 20 calendar days after the license holder receives the notice of closure. A timely request for reconsideration stays imposition of the license closure until the commissioner issues a decision on the request for reconsideration.

Subd. 3. **Reconsideration final.** The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 33. Minnesota Statutes 2018, section 245A.07, subdivision 1, is amended to read:

Subdivision 1. **Sanctions; appeals; license.** (a) In addition to making a license conditional under section 245A.06, the commissioner may suspend or revoke the license, impose a fine, or secure an injunction against the continuing operation of the program of a license holder who does not comply with applicable law or rule or who has nondisqualifying background study information, as described in section 245C.05, subdivision 4, that reflects on the license holder's ability to safely provide care to foster children. When applying sanctions authorized under this section, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program.

(b) If a license holder appeals the suspension or revocation of a license and the license holder continues to operate the program pending a final order on the appeal, the commissioner shall issue the license holder a temporary provisional license. Unless otherwise specified by the commissioner, variances in effect on the date of the license sanction under appeal continue under the temporary provisional license. If a license holder fails to comply with applicable law or rule while operating under a temporary provisional license, the commissioner may impose additional sanctions under this section and section 245A.06, and may terminate any prior variance. If a temporary provisional license is set to expire, a new temporary provisional license shall be issued to the license holder upon payment of any fee required under section 245A.10. The temporary provisional license shall expire on the date the final order is issued. If the license holder prevails on the appeal, a new nonprovisional license shall be issued for the remainder of the current license period.

(c) If a license holder is under investigation and the license issued under this chapter is due to expire before completion of the investigation, the program shall be issued a new license upon completion of the reapplication requirements and payment of any applicable license fee. Upon completion of the investigation, a licensing sanction may be imposed against the new license under this section, section 245A.06, or 245A.08.

(d) Failure to reapply or closure of a license issued under this chapter by the license holder prior to the completion of any investigation shall not preclude the commissioner from issuing a licensing sanction under this section~~,~~ or section 245A.06~~, or 245A.08~~ at the conclusion of the investigation.

**EFFECTIVE DATE.** Paragraph (a) is effective March 1, 2020. Paragraphs (c) and (d) are effective January 1, 2020.

Sec. 34. Minnesota Statutes 2018, section 245A.07, subdivision 2, is amended to read:

Subd. 2. **Temporary immediate suspension.** (a) The commissioner shall act immediately to temporarily suspend a license issued under this chapter if:

(1) the license holder's actions or failure to comply with applicable law or rule, or the actions of other individuals or conditions in the program, pose an imminent risk of harm to the health, safety, or rights of persons served by the program; ~~or~~

(2) while the program continues to operate pending an appeal of an order of revocation, the commissioner identifies one or more subsequent violations of law or rule which may adversely affect the health or safety of persons served by the program~~.~~; or

(3) the license holder is criminally charged in state or federal court with an offense that involves fraud or theft against a program administered by the commissioner.

(b) No state funds shall be made available or be expended by any agency or department of state, county, or municipal government for use by a license holder regulated under this chapter while a license issued under this chapter is under immediate suspension. A notice stating the reasons for the immediate suspension and informing the license holder of the right to an expedited hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612, must be delivered by personal service to the address shown on the application or the last known address of the license holder. The license holder may appeal an order immediately suspending a license. The appeal of an order immediately suspending a license must be made in writing by certified mail ~~or~~, personal service, or other means expressly set forth in the commissioner's order. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice that the license has been immediately suspended. If a request is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. A license holder and any controlling individual shall discontinue operation of the program upon receipt of the commissioner's order to immediately suspend the license.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 35. Minnesota Statutes 2018, section 245A.07, subdivision 2a, is amended to read:

Subd. 2a. **Immediate suspension expedited hearing.** (a) Within five working days of receipt of the license holder's timely appeal, the commissioner shall request assignment of an administrative law judge. The request must include a proposed date, time, and place of a hearing. A hearing must be conducted by an administrative law judge within 30 calendar days of the request for assignment, unless an extension is requested by either party and

granted by the administrative law judge for good cause. The commissioner shall issue a notice of hearing by certified mail or personal service at least ten working days before the hearing. The scope of the hearing shall be limited solely to the issue of whether the temporary immediate suspension should remain in effect pending the commissioner's final order under section 245A.08, regarding a licensing sanction issued under subdivision 3 following the immediate suspension. For suspensions under subdivision 2, paragraph (a), clause (1), the burden of proof in expedited hearings under this subdivision shall be limited to the commissioner's demonstration that reasonable cause exists to believe that the license holder's actions or failure to comply with applicable law or rule poses, or the actions of other individuals or conditions in the program poses an imminent risk of harm to the health, safety, or rights of persons served by the program. "Reasonable cause" means there exist specific articulable facts or circumstances which provide the commissioner with a reasonable suspicion that there is an imminent risk of harm to the health, safety, or rights of persons served by the program. When the commissioner has determined there is reasonable cause to order the temporary immediate suspension of a license based on a violation of safe sleep requirements, as defined in section 245A.1435, the commissioner is not required to demonstrate that an infant died or was injured as a result of the safe sleep violations. For suspensions under subdivision 2, paragraph (a), clause (2), the burden of proof in expedited hearings under this subdivision shall be limited to the commissioner's demonstration by a preponderance of the evidence that, since the license was revoked, the license holder committed additional violations of law or rule which may adversely affect the health or safety of persons served by the program.

(b) The administrative law judge shall issue findings of fact, conclusions, and a recommendation within ten working days from the date of hearing. The parties shall have ten calendar days to submit exceptions to the administrative law judge's report. The record shall close at the end of the ten-day period for submission of exceptions. The commissioner's final order shall be issued within ten working days from the close of the record. When an appeal of a temporary immediate suspension is withdrawn or dismissed, the commissioner shall issue a final order affirming the temporary immediate suspension within ten calendar days of the commissioner's receipt of the withdrawal or dismissal. Within 90 calendar days after a final order affirming an immediate suspension, the commissioner shall make a determination regarding whether a final licensing sanction shall be issued under subdivision 3. The license holder shall continue to be prohibited from operation of the program during this 90-day period.

(c) When the final order under paragraph (b) affirms an immediate suspension, and a final licensing sanction is issued under subdivision 3 and the license holder appeals that sanction, the license holder continues to be prohibited from operation of the program pending a final commissioner's order under section 245A.08, subdivision 5, regarding the final licensing sanction.

(d) For suspensions under subdivision 2, paragraph (a), clause (3), the burden of proof in expedited hearings under this subdivision shall be limited to the commissioner's demonstration by a preponderance of the evidence that a criminal complaint and warrant or summons was issued for the license holder that was not dismissed, and that the criminal charge is an offense that involves fraud or theft against a program administered by the commissioner.

Sec. 36. Minnesota Statutes 2018, section 245A.07, subdivision 3, is amended to read:

Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may suspend or revoke a license, or impose a fine if:

(1) a license holder fails to comply fully with applicable laws or rules including but not limited to the requirements of this chapter and chapter 245C;

(2) a license holder, a controlling individual, or an individual living in the household where the licensed services are provided or is otherwise subject to a background study has ~~a~~ been disqualified and the disqualification ~~which has~~ was not ~~been~~ set aside ~~under section 245C.22~~ and no variance has been granted;

(3) a license holder knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license, in connection with the background study status of an individual, during an investigation, or regarding compliance with applicable laws or rules; ~~or~~

(4) ~~after July 1, 2012, and upon request by the commissioner, a license holder fails to submit the information required of an applicant under section 245A.04, subdivision 1, paragraph (f) or (g).~~ a license holder is excluded from any program administered by the commissioner under section 245.095; or

(5) revocation is required under section 245A.04, subdivision 7, paragraph (d).

A license holder who has had a license issued under this chapter suspended, revoked, or has been ordered to pay a fine must be given notice of the action by certified mail or personal service. If mailed, the notice must be mailed to the address shown on the application

or the last known address of the license holder. The notice must state in plain language the reasons the license was suspended or revoked, or a fine was ordered.

(b) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits a timely appeal of an order suspending or revoking a license, the license holder may continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs ~~(g)~~ (f) and ~~(h)~~ (g), until the commissioner issues a final order on the suspension or revocation.

(c)(1) If the license holder was ordered to pay a fine, the notice must inform the license holder of the responsibility for payment of fines and the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an order to pay a fine must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the fine has been ordered. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order.

(2) The license holder shall pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies. If the license holder receives state funds, the state, county, or municipal agencies or departments responsible for administering the funds shall withhold payments and recover any payments made while the license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(3) A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail or personal service that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(4) Fines shall be assessed as follows:

(i) the license holder shall forfeit $1,000 for each determination of maltreatment of a child under section 626.556 or the maltreatment of a vulnerable adult under section 626.557 for which the license holder is determined responsible for the maltreatment under section 626.556, subdivision 10e, paragraph (i), or 626.557, subdivision 9c, paragraph (c);

(ii) if the commissioner determines that a determination of maltreatment for which the license holder is responsible is the result of maltreatment that meets the definition of serious maltreatment as defined in section 245C.02, subdivision 18, the license holder shall forfeit $5,000;

(iii) for a program that operates out of the license holder's home and a program licensed under Minnesota Rules, parts 9502.0300 to ~~9502.0495~~ 9502.0445, the fine assessed against the license holder shall not exceed $1,000 for each determination of maltreatment;

(iv) the license holder shall forfeit $200 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the provision of adequate staff-to-child or adult ratios, and failure to comply with background study requirements under chapter 245C; and

(v) the license holder shall forfeit $100 for each occurrence of a violation of law or rule other than those subject to a $5,000, $1,000, or $200 fine in items (i) to (iv).

For purposes of this section, "occurrence" means each violation identified in the commissioner's fine order. Fines assessed against a license holder that holds a license to provide home and community-based services, as identified in section 245D.03, subdivision 1, and a community residential setting or day services facility license under chapter 245D where the services are provided, may be assessed against both licenses for the same occurrence, but the combined amount of the fines shall not exceed the amount specified in this clause for that occurrence.

(5) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.

(d) Except for background study violations involving the failure to comply with an order to immediately remove an individual or an order to provide continuous, direct supervision, the commissioner shall not issue a fine under paragraph (c) relating to a background study violation to a license holder who self-corrects a background study violation before the

commissioner discovers the violation. A license holder who has previously exercised the provisions of this paragraph to avoid a fine for a background study violation may not avoid a fine for a subsequent background study violation unless at least 365 days have passed since the license holder self-corrected the earlier background study violation.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 37. Minnesota Statutes 2018, section 245A.10, subdivision 4, is amended to read:

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

| Licensed Capacity | Child Care Center License Fee |
|---|---|
| 1 to 24 persons | $200 |
| 25 to 49 persons | $300 |
| 50 to 74 persons | $400 |
| 75 to 99 persons | $500 |
| 100 to 124 persons | $600 |
| 125 to 149 persons | $700 |
| 150 to 174 persons | $800 |
| 175 to 199 persons | $900 |
| 200 to 224 persons | $1,000 |
| 225 or more persons | $1,100 |

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

| License Holder Annual Revenue | License Fee |
|---|---|
| less than or equal to $10,000 | ~~$200~~ $240 |
| greater than $10,000 but less than or equal to $25,000 | ~~$300~~ $360 |
| greater than $25,000 but less than or equal to $50,000 | ~~$400~~ $480 |
| greater than $50,000 but less than or equal to $100,000 | ~~$500~~ $600 |
| greater than $100,000 but less than or equal to $150,000 | ~~$600~~ $720 |

| | |
|---|---|
| greater than $150,000 but less than or equal to $200,000 | ~~$800~~ $960 |
| greater than $200,000 but less than or equal to $250,000 | ~~$1,000~~ $1,200 |
| greater than $250,000 but less than or equal to $300,000 | ~~$1,200~~ $1,440 |
| greater than $300,000 but less than or equal to $350,000 | ~~$1,400~~ $1,680 |
| greater than $350,000 but less than or equal to $400,000 | ~~$1,600~~ $1,920 |
| greater than $400,000 but less than or equal to $450,000 | ~~$1,800~~ $2,160 |
| greater than $450,000 but less than or equal to $500,000 | ~~$2,000~~ $2,400 |
| greater than $500,000 but less than or equal to $600,000 | ~~$2,250~~ $2,700 |
| greater than $600,000 but less than or equal to $700,000 | ~~$2,500~~ $3,000 |
| greater than $700,000 but less than or equal to $800,000 | ~~$2,750~~ $3,300 |
| greater than $800,000 but less than or equal to $900,000 | ~~$3,000~~ $3,600 |
| greater than $900,000 but less than or equal to $1,000,000 | ~~$3,250~~ $3,900 |
| greater than $1,000,000 but less than or equal to $1,250,000 | ~~$3,500~~ $4,200 |
| greater than $1,250,000 but less than or equal to $1,500,000 | ~~$3,750~~ $4,500 |
| greater than $1,500,000 but less than or equal to $1,750,000 | ~~$4,000~~ $4,800 |
| greater than $1,750,000 but less than or equal to $2,000,000 | ~~$4,250~~ $5,100 |
| greater than $2,000,000 but less than or equal to $2,500,000 | ~~$4,500~~ $5,400 |
| greater than $2,500,000 but less than or equal to $3,000,000 | ~~$4,750~~ $5,700 |
| greater than $3,000,000 but less than or equal to $3,500,000 | ~~$5,000~~ $6,000 |
| greater than $3,500,000 but less than or equal to $4,000,000 | ~~$5,500~~ $6,600 |
| greater than $4,000,000 but less than or equal to $4,500,000 | ~~$6,000~~ $7,200 |
| greater than $4,500,000 but less than or equal to $5,000,000 | ~~$6,500~~ $7,800 |
| greater than $5,000,000 but less than or equal to $7,500,000 | ~~$7,000~~ $9,000 |

| | |
|---|---|
| greater than $7,500,000 but less than or equal to $10,000,000 | ~~$8,500~~ $13,500 |
| greater than $10,000,000 but less than or equal to $12,500,000 | ~~$10,000~~ $18,000 |
| greater than $12,500,000 but less than or equal to $15,000,000 | ~~$14,000~~ $22,500 |
| greater than $15,000,000 but less than or equal to $17,500,000 | ~~$18,000~~ $27,000 |
| greater than $17,500,000 but less than or equal to $20,000,000 | $31,500 |
| greater than $20,000,000 but less than or equal to $25,000,000 | $36,000 |
| greater than $25,000,000 but less than or equal to $30,000,000 | $45,000 |
| greater than $30,000,000 but less than or equal to $35,000,000 | $54,000 |
| greater than $35,000,000 but less than or equal to $40,000,000 | $63,000 |
| greater than $40,000,000 | $72,000 |

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

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

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

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

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

| Licensed Capacity | License Fee |
|---|---|
| 1 to 24 persons | $600 |

| | |
|---|---|
| 25 to 49 persons | $800 |
| 50 to 74 persons | $1,000 |
| 75 to 99 persons | $1,200 |
| 100 or more persons | $1,400 |

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

| Licensed Capacity | License Fee |
|---|---|
| 1 to 24 persons | $760 |
| 25 to 49 persons | $960 |
| 50 or more persons | $1,160 |

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

| Licensed Capacity | License Fee |
|---|---|
| 1 to 24 persons | $1,000 |
| 25 to 49 persons | $1,100 |
| 50 to 74 persons | $1,200 |
| 75 to 99 persons | $1,300 |
| 100 or more persons | $1,400 |

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

| Licensed Capacity | License Fee |
|---|---|
| 1 to 24 persons | $2,525 |
| 25 or more persons | $2,725 |

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

| Licensed Capacity | License Fee |
|---|---|
| 1 to 24 persons | $450 |
| 25 to 49 persons | $650 |
| 50 to 74 persons | $850 |

| | |
|---|---|
| 75 to 99 persons | $1,050 |
| 100 or more persons | $1,250 |

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

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

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

| Licensed Capacity | License Fee |
|---|---|
| 1 to 24 persons | $500 |
| 25 to 49 persons | $700 |
| 50 to 74 persons | $900 |
| 75 to 99 persons | $1,100 |
| 100 or more persons | $1,300 |

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

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

Sec. 38. Minnesota Statutes 2018, section 245A.14, subdivision 4, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 39. Minnesota Statutes 2018, section 245A.14, subdivision 8, is amended to read:

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

(1) a teacher is in the facility;

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

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

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

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

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

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

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

Sec. 40. Minnesota Statutes 2018, section 245A.14, is amended by adding a subdivision to read:

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

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

Sec. 41. Minnesota Statutes 2018, section 245A.14, is amended by adding a subdivision to read:

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

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

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

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

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

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

Sec. 42. Minnesota Statutes 2018, section 245A.145, subdivision 1, is amended to read:

Subdivision 1. **Policies and procedures.** (a) ~~All licensed child care providers~~ The Department of Human Services must develop policies and procedures for reporting suspected child maltreatment that fulfill the requirements in section 626.556 and ~~must develop policies and procedures for reporting complaints about the operation of a child care program. The policies and procedures must include the telephone numbers of the local county child protection agency for reporting suspected maltreatment; the county licensing agency for family and group family child care providers; and the state licensing agency for child care centers.~~ provide the policies and procedures to all licensed child care providers. The policies and procedures must be written in plain language.

(b) The policies and procedures required in paragraph (a) must:

(1) be provided to the parents of all children at the time of enrollment in the child care program; and

(2) be made available upon request.

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

Sec. 43. Minnesota Statutes 2018, section 245A.145, subdivision 2, is amended to read:

Subd. 2. **Licensing agency phone number displayed.** ~~By July 1, 2002,~~ A new or renewed child care license must include the licensing agency's telephone number and a statement that informs parents who have ~~concerns~~ questions about their child's care that they may call the licensing agency. ~~The commissioner shall print the telephone number for the licensing agency in bold and large font on the license issued to child care providers.~~

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

Sec. 44. **[245A.149] SUPERVISION OF FAMILY CHILD CARE LICENSE HOLDER'S OWN CHILD.**

Notwithstanding Minnesota Rules, part 9502.0365, subpart 5, an individual may supervise the family child care license holder's own child both inside and outside of the licensed space, and is exempt from the requirements of this chapter and Minnesota Rules, chapter 9502, if the individual:

(1) is related to the license holder, as defined in section 245A.02, subdivision 13;

(2) is not a designated caregiver, helper, or substitute for the licensed program; and

(3) is involved only in the care of the license holder's own child.

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

Sec. 45. Minnesota Statutes 2018, section 245A.151, is amended to read:

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

When licensure under this chapter or certification under chapter 245H requires an inspection by a fire marshal to determine compliance with the State Fire Code under section 299F.011, a local fire code inspector approved by the state fire marshal may conduct the inspection. If a community does not have a local fire code inspector or if the local fire code inspector does not perform the inspection, the state fire marshal must conduct the inspection. A local fire code inspector or the state fire marshal may recover the cost of these inspections through a fee of no more than $50 per inspection charged to the applicant or license holder or license-exempt child care center certification holder. The fees collected by the state fire marshal under this section are appropriated to the commissioner of public safety for the purpose of conducting the inspections.

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

Sec. 46. Minnesota Statutes 2018, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private agencies that have been designated or licensed by the commissioner to perform licensing functions and activities under section 245A.04 and background studies for family child care under chapter 245C; to recommend denial of applicants under section 245A.05; to issue correction orders, to issue variances, and recommend a conditional license under section 245A.06; or to recommend suspending or revoking a license or issuing a fine under section 245A.07, shall comply with rules and directives of the commissioner governing those

functions and with this section. The following variances are excluded from the delegation of variance authority and may be issued only by the commissioner:

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

(2) adult foster care maximum capacity;

(3) adult foster care minimum age requirement;

(4) child foster care maximum age requirement;

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

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

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

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

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

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

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

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

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

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

(1) the role of counties in quality assurance;

(2) the duties of county licensing staff; and

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

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

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

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

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

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

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

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

Sec. 47. Minnesota Statutes 2018, section 245A.16, is amended by adding a subdivision to read:

Subd. 9. **Licensed family child foster care.** (a) Before recommending to deny a license under section 245A.05 or revoke a license under section 245A.07 for nondisqualifying background study information received under section 245C.05, subdivision 4, paragraph (a), clause (3), for licensed family child foster care a county agency or private agency that has been designated or licensed by the commissioner must review the following:

(1) the type of crime;

(2) the number of crimes;

(3) the nature of the offenses;

(4) the age of the individual at the time of conviction;

(5) the length of time that has elapsed since the last conviction;

(6) the relationship of the crime and the capacity to care for a child;

(7) evidence of rehabilitation;

(8) information or knowledge from community members regarding the individual's capacity to provide foster care;

(9) a statement from the study subject;

(10) a statement from the license holder; and

(11) other aggravating and mitigating factors.

(b) The county or private licensing agency must send a summary of the review completed according to paragraph (a), on a form developed by the commissioner, to the commissioner and include any recommendation for licensing action. The commissioner shall retain the final authority and responsibility for determining licensing actions.

**EFFECTIVE DATE.** This section is effective March 1, 2020.

Sec. 48. Minnesota Statutes 2018, section 245A.18, subdivision 2, is amended to read:

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

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

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

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

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

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

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

(e) Notwithstanding paragraph (a), for an emergency relative placement under section 245A.035, the commissioner may grant a variance to the training required by this subdivision for a relative who completes a child seat safety check up. The child seat safety check up trainer must be approved by the Department of Public Safety, Office of Traffic Safety, and must provide one-on-one instruction on placing a child of a specific age in the exact child passenger restraint in the motor vehicle in which the child will be transported. Once granted a variance, and if all other licensing requirements are met, the relative applicant may receive a license and may transport a relative foster child younger than eight years of age. A child seat safety check up must be completed each time a child requires a different size car seat according to car seat and vehicle manufacturer guidelines. A relative license holder must complete training that meets the other requirements of this subdivision prior to placement of another foster child younger than eight years of age in the home or prior to the renewal of the child foster care license.

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

Sec. 49. Minnesota Statutes 2018, section 245A.40, is amended to read:

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

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

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

(2) specific job responsibilities;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 4. **Cardiopulmonary resuscitation.** ~~(a) All teachers and assistant teachers in a child care center governed by Minnesota Rules, parts 9503.0005 to 9503.0170, and at least one staff person during field trips and when transporting children in care, must satisfactorily complete training in cardiopulmonary resuscitation (CPR) that includes CPR techniques~~

~~for infants and children and in the treatment of obstructed airways. The CPR training must be completed within 90 days of the start of work, unless the training has been completed within the previous two years. The CPR training must have been provided by an individual approved to provide CPR instruction, must be repeated at least once every two years, and must be documented in the staff person's records.~~

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

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

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

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

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

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

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

(c) The Pediatric CPR training must:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) pediatric first aid that meets the requirements of subdivision 3;

(3) pediatric cardiopulmonary resuscitation training that meets the requirements of subdivision 4;

(4) cultural dynamics training to increase awareness of cultural differences; and

(5) disabilities training to increase awareness of differing abilities of children.

(g) At least once every five years, in-service training must include child passenger restraint training that meets the requirements of subdivision 6, if applicable.

(h) The remaining hours of the in-service training requirement must be met by completing training in the following content areas of the Minnesota Knowledge and Competency Framework:

(1) Content area I: child development and learning;

(2) Content area II: developmentally appropriate learning experiences;

(3) Content area III: relationships with families;

(4) Content area IV: assessment, evaluation, and individualization;

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

(6) Content area VI: professionalism; ~~and~~

(7) Content area VII: health, safety, and nutrition; and

(8) Content area VIII: application through clinical experiences.

~~(b)~~ (i) For purposes of this subdivision, the following terms have the meanings given them.

(1) "Child development and learning training" ~~has the meaning given it in subdivision 2, paragraph (a).~~ means training in understanding how children develop physically, cognitively, emotionally, and socially and learn as part of the children's family, culture, and community.

(2) "Developmentally appropriate learning experiences" means creating positive learning experiences, promoting cognitive development, promoting social and emotional development, promoting physical development, and promoting creative development.

(3) "Relationships with families" means training on building a positive, respectful relationship with the child's family.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(f)~~ (j) The license holder must ensure that~~, when a staff person completes in-service training, the training is documented in the staff person's personnel record. The documentation must include the date training was completed, the goal of the training and topics covered, trainer's name and organizational affiliation, trainer's signed statement that training was successfully completed,~~ documentation, as required in subdivision 10, includes the number

of total training hours required to be completed, name of the training, the Minnesota Knowledge and Competency Framework content area, number of hours completed, and the director's approval of the training.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 50. Minnesota Statutes 2018, section 245A.41, is amended to read:

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

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

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

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

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

(e) The license holder must contact the child's parent or legal guardian as soon as possible in any instance of exposure or allergic reaction that requires medication or medical

intervention. The license holder must call emergency medical services when epinephrine is administered to a child in the license holder's care.

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

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

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

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

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

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

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

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

(2) a designated relocation site and evacuation route;

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

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

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

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

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

(8) accommodations for infants and toddlers.

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

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

(d) The license holder must review and update the emergency plan annually. Documentation of the annual emergency plan review shall be maintained in the program's administrative records.

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

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

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

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

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

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

Sec. 51. Minnesota Statutes 2018, section 245A.50, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Each helper must complete:

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 2. **Child development and learning and behavior guidance training.** (a) ~~For purposes of family and group family child care,~~ The license holder and each ~~adult~~ caregiver

~~who provides care in the licensed setting for more than 30 days in any 12-month period~~ shall complete ~~and document~~ at least four hours of child growth and learning and behavior guidance training prior to initial licensure, and before caring for children. ~~For purposes of this subdivision, "child development and learning training" means training in understanding how children develop physically, cognitively, emotionally, and socially and learn as part of the children's family, culture, and community. "Behavior guidance training" means training in the understanding of the functions of child behavior and strategies for managing challenging situations. At least two hours of child development and learning or behavior guidance training must be repeated annually. Training curriculum shall be developed or approved by the commissioner of human services.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(e)~~ (f) Sudden unexpected infant death reduction training and abusive head trauma training required under this subdivision must be completed in person or as allowed under subdivision 10, clause (1) or (2), at least once every two years. On the years when the license holder ~~is~~, caregiver, substitute, and helper are not receiving training in person or as allowed under subdivision 10, clause (1) or (2), the license holder, caregiver, substitute, and helper must receive sudden unexpected infant death reduction training and abusive head trauma

training through a video of no more than one hour in length. The video must be developed or approved by the commissioner.

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

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

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

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

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

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

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

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

Subd. 7. **Ongoing training requirements for family and group family child care license holders and caregivers.** ~~For purposes of family and group family child care,~~ (a)

The license holder and each ~~primary~~ caregiver must complete 16 hours of ongoing training each year. ~~For purposes of this subdivision, a primary caregiver is an adult caregiver who provides services in the licensed setting for more than 30 days in any 12-month period. Repeat of topical training requirements in subdivisions 2 to 8 shall count toward the annual 16-hour training requirement.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) online training; and

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

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

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

Subd. 13. **Training exemption.** An individual who is related to the license holder, as defined in section 245A.02, subdivision 13, who is involved only in the care of the family child care license holder's own child and who is not a designated caregiver, helper, or substitute for the licensed program is exempt from the training requirements in this section.

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

Sec. 52. Minnesota Statutes 2018, section 245A.51, subdivision 3, is amended to read:

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

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

(2) a designated relocation site and evacuation route;

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

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

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

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

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

(8) accommodations for infants and toddlers.

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

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

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

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

Sec. 53. Minnesota Statutes 2018, section 245A.51, is amended by adding a subdivision to read:

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

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

Sec. 54. Minnesota Statutes 2018, section 245A.51, is amended by adding a subdivision to read:

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

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

Sec. 55. **[245A.52] FAMILY CHILD CARE PHYSICAL SPACE REQUIREMENTS.**

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

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

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

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

Subd. 2. **Door to attached garage.** Notwithstanding Minnesota Rules, part 9502.0425, subpart 5, day care residences with an attached garage are not required to have a self-closing door to the residence. The door to the residence may be a steel insulated door if the door is at least 1-3/8 inches thick.

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

Subd. 4. **Fire extinguisher.** A portable, operational, multipurpose, dry chemical fire extinguisher with a minimum 2 A 10 BC rating must be located in or near the kitchen and

cooking areas of the residence at all times. The fire extinguisher must be serviced annually by a qualified inspector. All caregivers must know how to properly use the fire extinguisher.

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

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

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

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

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

Sec. 56. **[245A.53] SUBSTITUTE CAREGIVERS AND REPLACEMENTS IN FAMILY CHILD CARE.**

Subdivision 1. **Total hours allowed.** Notwithstanding Minnesota Rules, part 9502.0365, subpart 5, the use of a substitute caregiver in a licensed family child care program must be limited to a cumulative total of not more than 400 hours in a calendar year. The license holder must document the name, dates, and number of hours of the substitute who provided care.

Subd. 2. **Emergency replacement supervision.** (a) A license holder may allow an adult who has not completed the training requirements under this chapter or the background study requirements under chapter 245C to supervise children in a family child care program in an emergency. For purposes of this subdivision, an emergency is a situation in which:

(1) the license holder has begun operating the family child care program for the day and for reasons beyond the license holder's control, including, but not limited to a serious illness or injury, accident, or situation requiring the license holder's immediate attention, the license holder needs to leave the licensed space and close the program for the day; and

(2) the parents or guardians of the children attending the program are contacted to pick up their children as soon as is practicable.

(b) The license holder must make reasonable efforts to minimize the time the emergency replacement has unsupervised contact with the children in care, not to exceed 24 hours per emergency incident.

(c) The license holder shall not knowingly use a person as an emergency replacement who has committed an action or has been convicted of a crime that would cause the person to be disqualified from providing care to children, if a background study was conducted under chapter 245C.

(d) To the extent practicable, the license holder must attempt to arrange for emergency care by a substitute caregiver before using an emergency replacement.

(e) To the extent practicable, the license holder must notify the county licensing agency within seven days that an emergency replacement was used, and specify the circumstances that led to the use of the emergency replacement. The county licensing agency must notify the commissioner within three business days after receiving the license holder's notice that an emergency replacement was used, and specify the circumstances that led to the use of the emergency replacement.

(f) Notwithstanding the requirements in Minnesota Rules, part 9502.0405, a license holder is not required to provide the names of persons who may be used as substitutes or replacements in emergencies to parents or the county licensing agency.

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

Sec. 57. Minnesota Statutes 2018, section 245A.66, subdivision 2, is amended to read:

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

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

(1) an assessment of the risks presented by the physical plant where the licensed services are provided, including an evaluation of the following factors: the condition and design of

the facility and its outdoor space, bathrooms, storage areas, and accessibility of medications and cleaning products that are harmful to children when children are not supervised and the existence of areas that are difficult to supervise; and

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

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

(d) In addition to any program-specific risks identified in paragraph (b), the plan must include development and implementation of specific policies and procedures or refer to existing policies and procedures that minimize the risk of harm or injury to children, including:

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

(2) leaving children in the community without supervision;

(3) children leaving the facility without supervision;

(4) caregiver dislocation of children's elbows;

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

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

(7) sunburn;

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

(9) children falling from changing tables; and

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

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

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

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

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

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

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

(5) supervision of children in hallways~~.~~; and

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

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

Sec. 58. Minnesota Statutes 2018, section 245A.66, subdivision 3, is amended to read:

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

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

(1) the assessment factors in the plan;

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

(3) substantiated maltreatment findings, if any; and

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

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

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

Sec. 59. Minnesota Statutes 2018, section 245C.02, is amended by adding a subdivision to read:

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

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

Sec. 60. Minnesota Statutes 2018, section 245C.02, subdivision 6a, is amended to read:

Subd. 6a. **Child care background study subject.** (a) "Child care background study subject" means an individual who is affiliated with a licensed child care center, certified license exempt child care center, licensed family child care program, or legal nonlicensed child care provider authorized under chapter 119B, and who is:

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

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

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

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

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

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

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

(7) an individual who, without providing direct contact services at a licensed program, certified program, or program authorized under chapter 119B, may have unsupervised access

to a child receiving services from a program when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15; or

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

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

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

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

(3) the licensed child care center, certified license exempt child care center, licensed family child care program, or legal nonlicensed child care provider authorized under chapter 119B maintains documentation on-site that identifies the individual service provider and the services being provided; and

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

Sec. 61. Minnesota Statutes 2018, section 245C.02, is amended by adding a subdivision to read:

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

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

Sec. 62. Minnesota Statutes 2018, section 245C.02, is amended by adding a subdivision to read:

Subd. 12a. **Licensed family child foster care.** "Licensed family child foster care" includes providers who have submitted an application for family child foster care licensure under section 245A.04, subdivision 1. Licensed family child foster care does not include foster residence settings that meet the licensing requirements of Minnesota Rules, parts 2960.3200 to 2960.3230.

**EFFECTIVE DATE.** This section is effective March 1, 2020.

Sec. 63. Minnesota Statutes 2018, section 245C.02, is amended by adding a subdivision to read:

Subd. 20. **Substance use disorder treatment field.** "Substance use disorder treatment field" means a program exclusively serving individuals 18 years of age and older and that is required to be:

(1) licensed under chapter 245G; or

(2) registered under section 157.17 as a board and lodge establishment that predominantly serves individuals being treated for or recovering from a substance use disorder.

Sec. 64. Minnesota Statutes 2018, section 245C.03, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

~~(c)~~ (b) For child foster care when the license holder resides in the home where foster care services are provided, a short-term substitute caregiver providing direct contact services for a child for less than 72 hours of continuous care is not required to receive a background study under this chapter.

Sec. 65. Minnesota Statutes 2018, section 245C.05, subdivision 2c, is amended to read:

Subd. 2c. **Privacy notice to background study subject.** (a) Prior to initiating each background study, the entity initiating the study must provide the commissioner's privacy notice to the background study subject required under section 13.04, subdivision 2. The notice must be available through the commissioner's electronic NETStudy and NETStudy 2.0 systems and shall include the information in paragraphs (b) and (c).

(b) The background study subject shall be informed that any previous background studies that received a set-aside will be reviewed, and without further contact with the background study subject, the commissioner may notify the agency that initiated the subsequent background study:

(1) that the individual has a disqualification that has been set aside for the program or agency that initiated the study;

(2) the reason for the disqualification; and

(3) that information about the decision to set aside the disqualification will be available to the license holder upon request without the consent of the background study subject.

(c) The background study subject must also be informed that:

(1) the subject's fingerprints collected for purposes of completing the background study under this chapter must not be retained by the Department of Public Safety, Bureau of Criminal Apprehension, or by the commissioner. The Federal Bureau of Investigation will

~~only retain fingerprints of subjects with a criminal history~~ not retain background study subjects' fingerprints;

(2) effective upon implementation of NETStudy 2.0, the subject's photographic image will be retained by the commissioner, and if the subject has provided the subject's Social Security number for purposes of the background study, the photographic image will be available to prospective employers and agencies initiating background studies under this chapter to verify the identity of the subject of the background study;

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

(4) the commissioner shall provide the subject notice, as required in section 245C.17, subdivision 1, paragraph (a), when an entity initiates a background study on the individual;

(5) the subject may request in writing a report listing the entities that initiated a background study on the individual as provided in section 245C.17, subdivision 1, paragraph (b);

(6) the subject may request in writing that information used to complete the individual's background study in NETStudy 2.0 be destroyed if the requirements of section 245C.051, paragraph (a), are met; and

(7) notwithstanding clause (6), the commissioner shall destroy:

(i) the subject's photograph after a period of two years when the requirements of section 245C.051, paragraph (c), are met; and

(ii) any data collected on a subject under this chapter after a period of two years following the individual's death as provided in section 245C.051, paragraph (d).

Sec. 66. Minnesota Statutes 2018, section 245C.05, subdivision 2d, is amended to read:

Subd. 2d. **Fingerprint data notification.** The commissioner of human services shall notify all background study subjects under this chapter that the Department of Human Services, Department of Public Safety, and the Bureau of Criminal Apprehension do not retain fingerprint data after a background study is completed, and that the Federal Bureau

~~of Investigation only retains the fingerprints of subjects who have a criminal history~~ of Investigation will not retain background study subjects' fingerprints.

Sec. 67. Minnesota Statutes 2018, section 245C.05, subdivision 4, is amended to read:

Subd. 4. **Electronic transmission.** (a) For background studies conducted by the Department of Human Services, the commissioner shall implement a secure system for the electronic transmission of:

(1) background study information to the commissioner;

(2) background study results to the license holder;

(3) background study results and relevant underlying investigative information to county and private agencies for background studies conducted by the commissioner for child foster care, including a summary of nondisqualifying results, except as prohibited by law; and

(4) background study results to county agencies for background studies conducted by the commissioner for adult foster care and family adult day services and, upon implementation of NETStudy 2.0, family child care and legal nonlicensed child care authorized under chapter 119B.

(b) Unless the commissioner has granted a hardship variance under paragraph (c), a license holder or an applicant must use the electronic transmission system known as NETStudy or NETStudy 2.0 to submit all requests for background studies to the commissioner as required by this chapter.

(c) A license holder or applicant whose program is located in an area in which high-speed Internet is inaccessible may request the commissioner to grant a variance to the electronic transmission requirement.

(d) Section 245C.08, subdivision 3, paragraph (c), applies to results transmitted under this subdivision.

**EFFECTIVE DATE.** This section is effective March 1, 2020.

Sec. 68. Minnesota Statutes 2018, section 245C.05, subdivision 5, is amended to read:

Subd. 5. **Fingerprints and photograph.** (a) Notwithstanding paragraph (b), for background studies conducted by the commissioner for child foster care, children's residential facilities, adoptions, or a transfer of permanent legal and physical custody of a child, the subject of the background study, who is 18 years of age or older, shall provide the

commissioner with a set of classifiable fingerprints obtained from an authorized agency for a national criminal history record check.

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

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

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

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

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

**EFFECTIVE DATE.** Paragraph (a) is effective July 1, 2019, for background studies initiated on or after that date.

Sec. 69. Minnesota Statutes 2018, section 245C.05, subdivision 5a, is amended to read:

Subd. 5a. **Background study requirements for minors.** (a) A background study completed under this chapter on a subject who is required to be studied under section

245C.03, subdivision 1, and is 17 years of age or younger shall be completed by the commissioner for:

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

(2) a licensed family child care program; or

(3) a licensed foster care home.

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

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

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

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

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

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

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

Sec. 70. Minnesota Statutes 2018, section 245C.08, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

(b) Notwithstanding expungement by a court, the commissioner may consider information obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice

of the petition for expungement and the court order for expungement is directed specifically to the commissioner.

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

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

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

**EFFECTIVE DATE.** Paragraph (a) is effective July 1, 2019, for background studies initiated on or after that date.

Sec. 71. Minnesota Statutes 2018, section 245C.08, subdivision 3, is amended to read:

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

(1) the Bureau of Criminal Apprehension;

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

(3) a county attorney;

(4) a county sheriff;

(5) a county agency;

(6) a local chief of police;

(7) other states;

(8) the courts;

(9) the Federal Bureau of Investigation;

(10) the National Criminal Records Repository; and

(11) criminal records from other states.

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

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

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

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

Sec. 72. Minnesota Statutes 2018, section 245C.10, is amended by adding a subdivision to read:

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

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

Sec. 73. Minnesota Statutes 2018, section 245C.13, subdivision 2, is amended to read:

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

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

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

(i) the individual is not disqualified; or

(ii) more time is needed to complete the study but the individual is not required to be removed from direct contact or access to people receiving services prior to completion of the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice that more time is needed to complete the study must also indicate whether the individual is required to be under continuous direct supervision prior to completion of the background study;

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

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

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

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

(1) being issued a license;

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

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

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

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

Sec. 74. Minnesota Statutes 2018, section 245C.13, is amended by adding a subdivision to read:

Subd. 3. **Other state information.** If the commissioner has not received criminal, sex offender, or maltreatment information from another state that is required to be reviewed under this chapter within ten days of requesting the information, and the lack of the information is the only reason that a notice is issued under subdivision 2, paragraph (a),

clause (1), item (ii), the commissioner may issue a notice under subdivision 2, paragraph (a), clause (1), item (i). The commissioner may take action on information received from other states after issuing a notice under subdivision 2, paragraph (a), clause (1), item (ii).

Sec. 75. Minnesota Statutes 2018, section 245C.14, subdivision 1, is amended to read:

Subdivision 1. **Disqualification from direct contact.** (a) The commissioner shall disqualify an individual who is the subject of a background study from any position allowing direct contact with persons receiving services from the license holder or entity identified in section 245C.03, upon receipt of information showing, or when a background study completed under this chapter shows any of the following:

(1) a conviction of, admission to, or Alford plea to one or more crimes listed in section 245C.15, regardless of whether the conviction or admission is a felony, gross misdemeanor, or misdemeanor level crime;

(2) a preponderance of the evidence indicates the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, regardless of whether the preponderance of the evidence is for a felony, gross misdemeanor, or misdemeanor level crime; or

(3) an investigation results in an administrative determination listed under section 245C.15, subdivision 4, paragraph (b).

(b) No individual who is disqualified following a background study under section 245C.03, subdivisions 1 and 2, may be retained in a position involving direct contact with persons served by a program or entity identified in section 245C.03, unless the commissioner has provided written notice under section 245C.17 stating that:

(1) the individual may remain in direct contact during the period in which the individual may request reconsideration as provided in section 245C.21, subdivision 2;

(2) the commissioner has set aside the individual's disqualification for that program or entity identified in section 245C.03, as provided in section 245C.22, subdivision 4; or

(3) the license holder has been granted a variance for the disqualified individual under section 245C.30.

(c) Notwithstanding paragraph (a), for the purposes of a background study affiliated with a licensed family child foster care provider, the commissioner shall disqualify an individual who is the subject of a background study from any position allowing direct contact with persons receiving services from the license holder or entity identified in section 245C.03,

upon receipt of information showing, or when a background study completed under this chapter is disqualifying under section 245C.15, subdivision 6.

**EFFECTIVE DATE.** This section is effective March 1, 2020.

Sec. 76. Minnesota Statutes 2018, section 245C.15, subdivision 2, is amended to read:

Subd. 2. **15-year disqualification.** (a) An individual is disqualified under section 245C.14 if: (1) less than 15 years have passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a felony-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 268.182 (fraud); 393.07, subdivision 10, paragraph (c) (federal Food Stamp Program fraud); 609.165 (felon ineligible to possess firearm); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (suicide); 609.223 or 609.2231 (assault in the third or fourth degree); repeat offenses under 609.224 (assault in the fifth degree); 609.229 (crimes committed for benefit of a gang); 609.2325 (criminal abuse of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.235 (use of drugs to injure or facilitate crime); 609.24 (simple robbery); 609.255 (false imprisonment); 609.2664 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the commission of a crime); 609.27 (coercion); 609.275 (attempt to coerce); 609.466 (medical assistance fraud); 609.495 (aiding an offender); 609.498, subdivision 1 or 1b (aggravated first-degree or first-degree tampering with a witness); 609.52 (theft); 609.521 (possession of shoplifting gear); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.562 (arson in the second degree); 609.563 (arson in the third degree); 609.582 (burglary); 609.59 (possession of burglary tools); 609.611 (insurance fraud); 609.625 (aggravated forgery); 609.63 (forgery); 609.631 (check forgery; offering a forged check); 609.635 (obtaining signature by false pretense); 609.66 (dangerous weapons); 609.67 (machine guns and short-barreled shotguns); 609.687 (adulteration); 609.71 (riot); 609.713 (terroristic threats); 609.817 (criminal penalties for acts involving human services programs); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; repeat offenses under 617.241 (obscene materials and performances; distribution and exhibition prohibited; penalty); 624.713 (certain persons not to possess firearms); chapter 152 (drugs; controlled substance); or Minnesota Statutes 2012, section 609.21; or a felony-level conviction involving alcohol or drug use.

(b) An individual is disqualified under section 245C.14 if less than 15 years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

(c) An individual is disqualified under section 245C.14 if less than 15 years has passed since the termination of the individual's parental rights under section 260C.301, subdivision 1, paragraph (b), or subdivision 3.

(d) An individual is disqualified under section 245C.14 if less than 15 years has passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of the offenses listed in paragraph (a).

(e) If the individual studied commits one of the offenses listed in paragraph (a), but the sentence or level of offense is a gross misdemeanor or misdemeanor, the individual is disqualified but the disqualification look-back period for the offense is the period applicable to the gross misdemeanor or misdemeanor disposition.

(f) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on an Alford Plea, the disqualification period begins from the date the Alford Plea is entered in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

Sec. 77. Minnesota Statutes 2018, section 245C.15, subdivision 3, is amended to read:

Subd. 3. **Ten-year disqualification.** (a) An individual is disqualified under section 245C.14 if: (1) less than ten years have passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a gross misdemeanor-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 268.182 (fraud); 393.07, subdivision 10, paragraph (c) (federal Food Stamp Program fraud); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.221 or 609.222 (assault in the first or second degree); 609.223 or 609.2231 (assault in the third or fourth degree); 609.224 (assault in the fifth degree); 609.224, subdivision 2, paragraph (c) (assault in the fifth degree by a caregiver against a vulnerable adult); 609.2242 and 609.2243 (domestic assault); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal

neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.265 (abduction); 609.275 (attempt to coerce); 609.324, subdivision 1a (other prohibited acts; minor engaged in prostitution); 609.33 (disorderly house); 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child); 609.466 (medical assistance fraud); 609.52 (theft); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.582 (burglary); 609.59 (possession of burglary tools); 609.611 (insurance fraud); 609.631 (check forgery; offering a forged check); 609.66 (dangerous weapons); 609.71 (riot); 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); repeat offenses under 609.746 (interference with privacy); 609.749, subdivision 2 (stalking); 609.817 (criminal penalties for acts involving human services programs); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; 617.241 (obscene materials and performances); 617.243 (indecent literature, distribution); 617.293 (harmful materials; dissemination and display to minors prohibited); or Minnesota Statutes 2012, section 609.21; or violation of an order for protection under section 518B.01, subdivision 14.

(b) An individual is disqualified under section 245C.14 if less than ten years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

(c) An individual is disqualified under section 245C.14 if less than ten years has passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraph (a).

(d) If the individual studied commits one of the offenses listed in paragraph (a), but the sentence or level of offense is a misdemeanor disposition, the individual is disqualified but the disqualification lookback period for the offense is the period applicable to misdemeanors.

(e) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on an Alford Plea, the disqualification period begins from the date the Alford Plea is entered in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

Sec. 78. Minnesota Statutes 2018, section 245C.15, subdivision 4, is amended to read:

Subd. 4. **Seven-year disqualification.** (a) An individual is disqualified under section 245C.14 if: (1) less than seven years has passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a misdemeanor-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 268.182 (fraud); 393.07, subdivision 10, paragraph (c) (federal Food Stamp Program fraud); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.221 (assault in the first degree); 609.222 (assault in the second degree); 609.223 (assault in the third degree); 609.2231 (assault in the fourth degree); 609.224 (assault in the fifth degree); 609.2242 (domestic assault); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.2672 (assault of an unborn child in the third degree); 609.27 (coercion); violation of an order for protection under 609.3232 (protective order authorized; procedures; penalties); 609.466 (medical assistance fraud); 609.52 (theft); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.611 (insurance fraud); 609.66 (dangerous weapons); 609.665 (spring guns); 609.746 (interference with privacy); 609.79 (obscene or harassing telephone calls); 609.795 (letter, telegram, or package; opening; harassment); 609.817 (criminal penalties for acts involving human services programs); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; 617.293 (harmful materials; dissemination and display to minors prohibited); or Minnesota Statutes 2012, section 609.21; or violation of an order for protection under section 518B.01 (Domestic Abuse Act).

(b) An individual is disqualified under section 245C.14 if less than seven years has passed since a determination or disposition of the individual's:

(1) failure to make required reports under section 626.556, subdivision 3, or 626.557, subdivision 3, for incidents in which: (i) the final disposition under section 626.556 or 626.557 was substantiated maltreatment, and (ii) the maltreatment was recurring or serious; or

(2) substantiated serious or recurring maltreatment of a minor under section 626.556, a vulnerable adult under section 626.557, or serious or recurring maltreatment in any other state, the elements of which are substantially similar to the elements of maltreatment under section 626.556 or 626.557 for which: (i) there is a preponderance of evidence that the maltreatment occurred, and (ii) the subject was responsible for the maltreatment.

(c) An individual is disqualified under section 245C.14 if less than seven years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota Statutes.

(d) An individual is disqualified under section 245C.14 if less than seven years has passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraphs (a) and (b).

(e) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on an Alford Plea, the disqualification period begins from the date the Alford Plea is entered in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

(f) An individual is disqualified under section 245C.14 if less than seven years has passed since the individual was disqualified under section 256.98, subdivision 8.

Sec. 79. Minnesota Statutes 2018, section 245C.15, is amended by adding a subdivision to read:

Subd. 6. **Licensed family child foster care disqualifications.** (a) Notwithstanding subdivisions 1 to 5, for a background study affiliated with a licensed family child foster care, an individual is disqualified under section 245C.14, regardless of how much time has passed, if the individual committed an act that resulted in a felony-level conviction for: 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); 609.2112 (criminal vehicular homicide); 609.223, subdivision 2 (assault in the third degree, past pattern of child abuse); 609.223, subdivision 3 (assault in the third degree, victim under four); a felony offense under sections 609.2242 and 609.2243 (domestic assault), spousal abuse, child abuse or neglect, or a crime against children; 609.2247 (domestic assault by strangulation); 609.25 (kidnapping); 609.255 (false imprisonment); 609.265 (abduction); 609.2661 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663 (murder of an unborn child in the third degree); 609.2664 (manslaughter of an unborn child in the first degree); 609.2665

(manslaughter of an unborn child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the commission of a crime); 609.324, subdivision 1 (other prohibited acts; engaging in, hiring, or agreeing to hire minor to engage in prostitution); 609.342 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in the second degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal sexual conduct in the fourth degree); 609.3451 (criminal sexual conduct in the fifth degree); 609.3453 (criminal sexual predatory conduct); 609.352 (solicitation of children to engage in sexual conduct); 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child); 617.246 (use of minors in sexual performance prohibited); or 617.247 (possession of pictorial representations of minors).

(b) Notwithstanding subdivisions 1 to 5, for the purposes of a background study affiliated with a licensed family foster care license, an individual is disqualified under section 245C.14, regardless of how much time has passed, if the individual:

(1) committed an action under paragraph (d) that resulted in death or involved sexual abuse;

(2) committed an act that resulted in a felony-level conviction for section 609.746 (interference with privacy);

(3) committed an act that resulted in a gross misdemeanor-level conviction for section 609.3451 (criminal sexual conduct in the fifth degree); or

(4) committed an act against or involving a minor that resulted in a felony-level conviction for: section 609.221 (assault in the first degree); 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the third degree); 609.2231 (assault in the fourth degree); or 609.224, subdivision 4 (assault in the fifth degree).

(c) Notwithstanding subdivisions 1 to 5, for a background study affiliated with a licensed family child foster care license, an individual is disqualified under section 245C.14 if:

(1) less than five years have passed since the termination of parental rights under section 260C.301, subdivision 1, paragraph (b);

(2) less than five years have passed since a felony-level conviction for: 152.021 (controlled substance crime in the first degree); 152.022 (controlled substance crime in the second degree); 152.023 (controlled substance crime in the third degree); 152.024 (controlled substance crime in the fourth degree); 152.025 (controlled substance crime in the fifth degree); 152.0261 (importing controlled substances across state borders); 152.0262,

subdivision 1, paragraph (b) (possession of substance with intent to manufacture methamphetamine); 152.027, subdivision 6, paragraph (c) (sale or possession of synthetic cannabinoids); 152.096 (conspiracies prohibited); 152.097 (simulated controlled substances); 152.136 (anhydrous ammonia; prohibited conduct; criminal penalties; civil liabilities); 152.137 (methamphetamine-related crimes involving children or vulnerable adults); 169A.24 (felony first-degree driving while impaired); 609.2113 (criminal vehicular operation; bodily harm); 609.2114 (criminal vehicular operation; unborn child); 609.228 (great bodily harm caused by distribution of drugs); 609.2325 (criminal abuse of a vulnerable adult); 609.235 (use of drugs to injure or facilitate a crime); 609.66, subdivision 1e (felony drive-by shooting); 609.687 (adulteration); or 609.855, subdivision 5 (shooting at or in a public transit vehicle or facility); or

(3) less than five years have passed since a felony-level conviction for an act not against or involving a minor under: section 609.221 (assault in the first degree); 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the third degree); 609.2231 (assault in the fourth degree); or 609.224, subdivision 4 (assault in the fifth degree).

(d) Notwithstanding subdivisions 1 to 5, except as provided in paragraph (a), for a background study affiliated with a licensed family child foster care license, an individual is disqualified under section 245C.14 if less than five years have passed since:

(1) a determination or disposition of the individual's failure to make required reports under section 626.556, subdivision 3, or 626.557, subdivision 3, for incidents in which the final disposition under section 626.556 or 626.557 was substantiated maltreatment and the maltreatment was recurring or serious;

(2) a determination or disposition of the individual's substantiated serious or recurring maltreatment of a minor under section 626.556, a vulnerable adult under section 626.557, or serious or recurring maltreatment in any other state, the elements of which are substantially similar to the elements of maltreatment under section 626.556 or 626.557 and meet the definition of serious maltreatment or recurring maltreatment;

(3) the termination of the individual's parental rights under section 260C.301, subdivision 1, paragraph (a); or

(4) a gross misdemeanor-level conviction for: section 609.746 (interference with privacy); 609.2242 and 609.2243 (domestic assault); 609.377 (malicious punishment of a child); or 609.378 (neglect or endangerment of a child).

(e) An individual is disqualified under this subdivision if the individual is convicted of an offense in any other state or country and the elements of the offense are substantially similar to any of the offenses listed in this subdivision.

**EFFECTIVE DATE.** This section is effective March 1, 2020.

Sec. 80. Minnesota Statutes 2018, section 245C.22, subdivision 4, is amended to read:

Subd. 4. **Risk of harm; set aside.** (a) The commissioner may set aside the disqualification if the commissioner finds that the individual has submitted sufficient information to demonstrate that the individual does not pose a risk of harm to any person served by the applicant, license holder, or other entities as provided in this chapter.

(b) In determining whether the individual has met the burden of proof by demonstrating the individual does not pose a risk of harm, the commissioner shall consider:

(1) the nature, severity, and consequences of the event or events that led to the disqualification;

(2) whether there is more than one disqualifying event;

(3) the age and vulnerability of the victim at the time of the event;

(4) the harm suffered by the victim;

(5) vulnerability of persons served by the program;

(6) the similarity between the victim and persons served by the program;

(7) the time elapsed without a repeat of the same or similar event;

(8) documentation of successful completion by the individual studied of training or rehabilitation pertinent to the event; and

(9) any other information relevant to reconsideration.

(c) If the individual requested reconsideration on the basis that the information relied upon to disqualify the individual was incorrect or inaccurate and the commissioner determines that the information relied upon to disqualify the individual is correct, the commissioner must also determine if the individual poses a risk of harm to persons receiving services in accordance with paragraph (b).

(d) For an individual seeking employment in the substance use disorder treatment field, the commissioner shall set aside the disqualification if the following criteria are met:

(1) the individual is not disqualified for a crime of violence as listed under section 624.712, subdivision 5, except for the following crimes: crimes listed under section 152.021, subdivision 2 or 2a; 152.022, subdivision 2; 152.023, subdivision 2; 152.024; or 152.025;

(2) the individual is not disqualified under section 245C.15, subdivision 1;

(3) the individual is not disqualified under section 245C.15, subdivision 4, paragraph (b);

(4) the individual provided documentation of successful completion of treatment, at least one year prior to the date of the request for reconsideration, at a program licensed under chapter 245G, and has had no disqualifying crimes or conduct under section 245C.15 after the successful completion of treatment;

(5) the individual provided documentation demonstrating abstinence from controlled substances, as defined in section 152.01, subdivision 4, for the period of one year prior to the date of the request for reconsideration; and

(6) the individual is seeking employment in the substance use disorder treatment field.

Sec. 81. Minnesota Statutes 2018, section 245C.22, subdivision 5, is amended to read:

Subd. 5. **Scope of set-aside.** (a) If the commissioner sets aside a disqualification under this section, the disqualified individual remains disqualified, but may hold a license and have direct contact with or access to persons receiving services. Except as provided in paragraph (b), the commissioner's set-aside of a disqualification is limited solely to the licensed program, applicant, or agency specified in the set aside notice under section 245C.23. For personal care provider organizations, the commissioner's set-aside may further be limited to a specific individual who is receiving services. For new background studies required under section 245C.04, subdivision 1, paragraph (h), if an individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

(b) If the commissioner has previously set aside an individual's disqualification for one or more programs or agencies, and the individual is the subject of a subsequent background study for a different program or agency, the commissioner shall determine whether the disqualification is set aside for the program or agency that initiated the subsequent background study. A notice of a set-aside under paragraph (c) shall be issued within 15 working days if all of the following criteria are met:

(1) the subsequent background study was initiated in connection with a program licensed or regulated under the same provisions of law and rule for at least one program for which the individual's disqualification was previously set aside by the commissioner;

(2) the individual is not disqualified for an offense specified in section 245C.15, subdivision 1 or 2;

(3) the commissioner has received no new information to indicate that the individual may pose a risk of harm to any person served by the program; and

(4) the previous set-aside was not limited to a specific person receiving services.

(c) Notwithstanding paragraph (b), clause (2), for an individual who is employed in the substance use disorder field, if the commissioner has previously set aside an individual's disqualification for one or more programs or agencies in the substance use disorder treatment field, and the individual is the subject of a subsequent background study for a different program or agency in the substance use disorder treatment field, the commissioner shall set aside the disqualification for the program or agency in the substance use disorder treatment field that initiated the subsequent background study when the criteria under paragraph (b), clauses (1), (3), and (4), are met and the individual is not disqualified for an offense specified in section 254C.15, subdivision 1. A notice of a set-aside under paragraph (d) shall be issued within 15 working days.

~~(c)~~ (d) When a disqualification is set aside under paragraph (b), the notice of background study results issued under section 245C.17, in addition to the requirements under section 245C.17, shall state that the disqualification is set aside for the program or agency that initiated the subsequent background study. The notice must inform the individual that the individual may request reconsideration of the disqualification under section 245C.21 on the basis that the information used to disqualify the individual is incorrect.

Sec. 82. Minnesota Statutes 2018, section 245C.24, is amended to read:

**245C.24 DISQUALIFICATION; BAR TO SET ASIDE A DISQUALIFICATION; REQUEST FOR VARIANCE.**

Subdivision 1. **Minimum disqualification periods.** The disqualification periods under subdivisions 3 ~~and 4~~ to 6 are the minimum applicable disqualification periods. The commissioner may determine that an individual should continue to be disqualified from licensure because the individual continues to pose a risk of harm to persons served by that individual, even after the minimum disqualification period has passed.

Subd. 2. **Permanent bar to set aside a disqualification.** (a) Except as provided in ~~paragraph~~ paragraphs (b)~~,~~ to (d), the commissioner may not set aside the disqualification of any individual disqualified pursuant to this chapter, regardless of how much time has passed, if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 1.

(b) For an individual ~~in the chemical dependency or corrections field~~ who was disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and ~~whose disqualification was set aside prior to July 1, 2005~~ more than 20 years have passed since the discharge of the sentence imposed or, if the disqualification is not based on a conviction, more than 20 years have passed since the individual committed the act upon which the disqualification was based, the commissioner must consider granting a set aside or variance pursuant to section 245C.22 or 245C.30 for the license holder for a program dealing primarily with adults. ~~A request for reconsideration evaluated under this paragraph must include a letter of recommendation from the license holder that was subject to the prior set-aside decision addressing the individual's quality of care to children or vulnerable adults and the circumstances of the individual's departure from that service~~ This paragraph does not apply to a person disqualified based on a violation of sections 609.342 to 609.3453; 617.23, subdivision 2, clause (1), or subdivision 3, clause (1); 617.246; or 617.247.

(c) When a licensed foster care provider adopts an individual who had received foster care services from the provider for over six months, and the adopted individual is required to receive a background study under section 245C.03, subdivision 1, paragraph (a), clause (2) or (6), the commissioner may grant a variance to the license holder under section 245C.30 to permit the adopted individual with a permanent disqualification to remain affiliated with the license holder under the conditions of the variance when the variance is recommended by the county of responsibility for each of the remaining individuals in placement in the home and the licensing agency for the home.

(d) For an individual 18 years of age or older affiliated with a licensed family child foster care program, the commissioner must not set aside the disqualification of any individual disqualified pursuant to this chapter, regardless of how much time has passed, if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 6, paragraph (a). This paragraph does not apply to an individual younger than 18 years of age at the time the background study is submitted.

Subd. 3. **Ten-year bar to set aside disqualification.** (a) The commissioner may not set aside the disqualification of an individual in connection with a license to provide family child care for children~~, foster care for children in the provider's home,~~ or foster care or day

care services for adults in the provider's home if: (1) less than ten years has passed since the discharge of the sentence imposed, if any, for the offense; or (2) when disqualified based on a preponderance of the evidence determination under section 245C.14, subdivision 1, paragraph (a), clause (2), or an admission under section 245C.14, subdivision 1, paragraph (a), clause (1), and less than ten years has passed since the individual committed the act or admitted to committing the act, whichever is later; and (3) the individual has committed a violation of any of the following offenses: sections 609.165 (felon ineligible to possess firearm); criminal vehicular homicide or criminal vehicular operation causing death under 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (aiding suicide or aiding attempted suicide); felony violations under 609.223 or 609.2231 (assault in the third or fourth degree); 609.229 (crimes committed for benefit of a gang); 609.713 (terroristic threats); 609.235 (use of drugs to injure or to facilitate crime); 609.24 (simple robbery); 609.255 (false imprisonment); 609.562 (arson in the second degree); 609.71 (riot); 609.498, subdivision 1 or 1b (aggravated first-degree or first-degree tampering with a witness); burglary in the first or second degree under 609.582 (burglary); 609.66 (dangerous weapon); 609.665 (spring guns); 609.67 (machine guns and short-barreled shotguns); 609.749, subdivision 2 (gross misdemeanor stalking); 152.021 or 152.022 (controlled substance crime in the first or second degree); 152.023, subdivision 1, clause (3) or (4) or subdivision 2, clause (4) (controlled substance crime in the third degree); 152.024, subdivision 1, clause (2), (3), or (4) (controlled substance crime in the fourth degree); 609.224, subdivision 2, paragraph (c) (fifth-degree assault by a caregiver against a vulnerable adult); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report); 609.265 (abduction); 609.2664 to 609.2665 (manslaughter of an unborn child in the first or second degree); 609.267 to 609.2672 (assault of an unborn child in the first, second, or third degree); 609.268 (injury or death of an unborn child in the commission of a crime); repeat offenses under 617.23 (indecent exposure); 617.293 (disseminating or displaying harmful material to minors); a felony-level conviction involving alcohol or drug use, a gross misdemeanor offense under 609.324, subdivision 1 (other prohibited acts); a gross misdemeanor offense under 609.378 (neglect or endangerment of a child); a gross misdemeanor offense under 609.377 (malicious punishment of a child); 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); or 624.713 (certain persons not to possess firearms); or Minnesota Statutes 2012, section 609.21.

(b) The commissioner may not set aside the disqualification of an individual if less than ten years have passed since the individual's aiding and abetting, attempt, or conspiracy to

commit any of the offenses listed in paragraph (a) as each of these offenses is defined in Minnesota Statutes.

(c) The commissioner may not set aside the disqualification of an individual if less than ten years have passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraph (a).

Subd. 4. **Seven-year bar to set aside disqualification.** The commissioner may not set aside the disqualification of an individual in connection with a license to provide family child care for children~~, foster care for children in the provider's home,~~ or foster care or day care services for adults in the provider's home if within seven years preceding the study:

(1) the individual committed an act that constitutes maltreatment of a child under section 626.556, subdivision 10e, and the maltreatment resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence; or

(2) the individual was determined under section 626.557 to be the perpetrator of a substantiated incident of maltreatment of a vulnerable adult that resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence.

Subd. 5. **Five-year bar to set aside disqualification.** The commissioner must not set aside the disqualification of an individual 18 years of age or older in connection with a family child foster care license if the individual is disqualified under section 245C.15, subdivision 6, paragraph (c). This paragraph does not apply to an individual younger than 18 years of age at the time the background study is submitted.

Subd. 6. **Five-year bar to set aside disqualification; children's residential facilities.** The commissioner shall not set aside the disqualification of an individual in connection with a license for a children's residential facility who was convicted of a felony within the past five years for: (1) physical assault or battery; or (2) a drug-related offense.

**EFFECTIVE DATE.** This section is effective March 1, 2020, except subdivision 6 is effective for background studies initiated on or after July 1, 2019.

Sec. 83. Minnesota Statutes 2018, section 245C.30, subdivision 1, is amended to read:

Subdivision 1. **License holder and license-exempt child care center certification holder variance.** (a) Except for any disqualification under section 245C.15, subdivision 1, when the commissioner has not set aside a background study subject's disqualification, and

there are conditions under which the disqualified individual may provide direct contact services or have access to people receiving services that minimize the risk of harm to people receiving services, the commissioner may grant a time-limited variance to a license holder or license-exempt child care center certification holder.

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

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

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

Sec. 84. Minnesota Statutes 2018, section 245C.30, subdivision 2, is amended to read:

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

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

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

Sec. 85. Minnesota Statutes 2018, section 245C.30, subdivision 3, is amended to read:

Subd. 3. **Consequences for failing to comply with conditions of variance.** When a license holder or license-exempt child care center certification holder permits a disqualified

individual to provide any services for which the subject is disqualified without complying with the conditions of the variance, the commissioner may terminate the variance effective immediately and subject the license holder to a licensing action under sections 245A.06 and 245A.07 or a license-exempt child care center certification holder to an action under sections 245H.06 and 245H.07.

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

Sec. 86. Minnesota Statutes 2018, section 245E.01, subdivision 8, is amended to read:

Subd. 8. **Financial misconduct or misconduct.** "Financial misconduct" or "misconduct" means an entity's or individual's acts or omissions that result in fraud and abuse or error against the Department of Human Services. Financial misconduct includes: (1) acting as a recruiter offering conditional employment on behalf of a provider that has received funds from the child care assistance program; and (2) committing an act or acts that meet the definition of offenses listed in sections 609.816 and 609.817.

Sec. 87. Minnesota Statutes 2018, section 245E.02, is amended by adding a subdivision to read:

Subd. 1a. **Provider definitions.** For the purposes of this section, "provider" includes:

(1) individuals or entities meeting the definition of provider in section 245E.01, subdivision 12; and

(2) owners and controlling individuals of entities identified in clause (1).

Sec. 88. Minnesota Statutes 2018, section 245H.01, is amended by adding a subdivision to read:

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

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

Sec. 89. Minnesota Statutes 2018, section 245H.01, is amended by adding a subdivision to read:

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

**EFFECTIVE DATE.** This section is effective September 30, 2019.

Sec. 90. Minnesota Statutes 2018, section 245H.01, is amended by adding a subdivision to read:

Subd. 9. **Unsupervised volunteer.** "Unsupervised volunteer" means an individual who: (1) assists in the care of a child in care; (2) is not under the continuous direct supervision of a staff person; and (3) is not employed by the certified center.

**EFFECTIVE DATE.** This section is effective September 30, 2019.

Sec. 91. Minnesota Statutes 2018, section 245H.03, is amended by adding a subdivision to read:

Subd. 4. **Reconsideration of certification denial.** (a) The applicant may request reconsideration of the denial by notifying the commissioner by certified mail or personal service. The request must be made in writing. If sent by certified mail, the request must be postmarked and sent to the commissioner within ten calendar days after the applicant received the order. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the applicant received the order. The applicant may submit with the request for reconsideration a written argument or evidence in support of the request for reconsideration.

(b) The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

**EFFECTIVE DATE.** This section is effective September 30, 2019.

Sec. 92. Minnesota Statutes 2018, section 245H.07, is amended to read:

**245H.07 DECERTIFICATION.**

Subdivision 1. **Generally.** (a) The commissioner may decertify a center if a certification holder:

(1) failed to comply with an applicable law or rule; ~~or~~

(2) knowingly withheld relevant information from or gave false or misleading information to the commissioner in connection with an application for certification, in connection with the background study status of an individual, during an investigation, or regarding compliance with applicable laws or rules~~.~~; or

(3) has authorization to receive child care assistance payments revoked pursuant to chapter 119B.

(b) When considering decertification, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule.

(c) When a center is decertified, the center is ineligible to receive a child care assistance payment under chapter 119B.

Subd. 2. **Reconsideration of decertification.** (a) The certification holder may request reconsideration of the decertification by notifying the commissioner by certified mail or personal service. The request must be made in writing. If sent by certified mail, the request must be postmarked and sent to the commissioner within ten calendar days after the certification holder received the order. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the certification holder received the order. With the request for reconsideration, the certification holder may submit a written argument or evidence in support of the request for reconsideration.

(b) The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

Subd. 3. **Decertification due to maltreatment.** If the commissioner decertifies a center pursuant to subdivision 1, paragraph (a), clause (1), based on a determination that the center was responsible for maltreatment, and if the center requests reconsideration of the decertification according to subdivision 2, paragraph (a), and appeals the maltreatment determination under section 626.556, subdivision 10i, the final decertification determination is stayed until the commissioner issues a final decision regarding the maltreatment appeal.

Subd. 4. **Decertification due to revocation of child care assistance.** If the commissioner decertifies a center that had payments revoked pursuant to chapter 119B, and if the center appeals the revocation of the center's authorization to receive child care assistance payments, the final decertification determination is stayed until the appeal of the center's authorization under chapter 119B is resolved. If the center also requests reconsideration of the decertification, the center must do so according to subdivision 2, paragraph (a). The final decision on reconsideration is stayed until the appeal of the center's authorization under chapter 119B is resolved.

**EFFECTIVE DATE.** Subdivisions 1 to 3 are effective September 30, 2019. Subdivision 4 is effective February 26, 2021.

Sec. 93. Minnesota Statutes 2018, section 245H.10, subdivision 1, is amended to read:

Subdivision 1. ~~**Documentation**~~ **Individuals to be studied.** (a) The applicant or certification holder must submit ~~and maintain documentation of~~ a completed background

study for~~:~~ each child care background study subject as defined in section 245C.02, subdivision 6a.

~~(1) each person applying for the certification;~~

~~(2) each person identified as a center operator or program operator as defined in section 245H.01, subdivision 3;~~

~~(3) each current or prospective staff person or contractor of the certified center who will have direct contact with a child served by the center;~~

~~(4) each volunteer who has direct contact with a child served by the center if the contact is not under the continuous, direct supervision by an individual listed in clause (1), (2), or (3); and~~

~~(5) each managerial staff person of the certification holder with oversight and supervision of the certified center.~~

(b) To be accepted for certification, a background study on every individual ~~in paragraph (a), clause (1),~~ applying for certification must be completed under chapter 245C and result in a not disqualified determination under section 245C.14 or a disqualification that was set aside under section 245C.22.

Sec. 94. Minnesota Statutes 2018, section 245H.11, is amended to read:

**245H.11 REPORTING.**

(a) The certification holder must comply and must have written policies for staff to comply with the reporting requirements for abuse and neglect specified in section 626.556. A person mandated to report physical or sexual child abuse or neglect occurring within a certified center shall report the information to the commissioner.

(b) The certification holder must inform the commissioner within 24 hours of:

(1) the death of a child in the program; and

(2) any injury to a child in the program that required treatment by a physician.

**EFFECTIVE DATE.** This section is effective September 30, 2019.

Sec. 95. Minnesota Statutes 2018, section 245H.12, is amended to read:

**245H.12 FEES.**

~~The commissioner shall consult with stakeholders to develop an administrative fee to implement this chapter. By February 15, 2019, the commissioner shall provide~~

~~recommendations on the amount of an administrative fee to the legislative committees with jurisdiction over health and human services policy and finance.~~ A certified center must pay an initial application fee of $200. For calendar year 2020 and thereafter, a certified center shall pay an annual nonrefundable certification fee of $100.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 96. Minnesota Statutes 2018, section 245H.13, subdivision 5, is amended to read:

Subd. 5. **Building and physical premises; free of hazards.** (a) ~~The certified center must document compliance with the State Fire Code by providing~~ To be accepted for certification, the applicant must demonstrate compliance with the State Fire Code, section 299F.011, by either:

(1) providing documentation of a fire marshal inspection completed within the previous three years by a state fire marshal or a local fire code inspector trained by the state fire marshal~~.~~; or

(2) complying with the fire marshal inspection requirements according to section 245A.151.

(b) The certified center must designate a primary indoor and outdoor space used for child care on a facility site floor plan.

(c) The certified center must ensure the areas used by a child are clean and in good repair, with structurally sound and functional furniture and equipment that is appropriate to the age and size of a child who uses the area.

(d) The certified center must ensure hazardous items including but not limited to sharp objects, medicines, cleaning supplies, poisonous plants, and chemicals are out of reach of a child.

(e) The certified center must safely handle and dispose of bodily fluids and other potentially infectious fluids by using gloves, disinfecting surfaces that come in contact with potentially infectious bodily fluids, and disposing of bodily fluid in a securely sealed plastic bag.

**EFFECTIVE DATE.** This section is effective September 30, 2019.

Sec. 97. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision to read:

Subd. 7. **Risk reduction plan.** (a) The certified center must develop a risk reduction plan that identifies risks to children served by the child care center. The assessment of risk must include risks presented by (1) the physical plant where the certified services are provided, including electrical hazards; and (2) the environment, including the proximity to busy roads and bodies of water.

(b) The certification holder must establish policies and procedures to minimize identified risks. After any change to the risk reduction plan, the certification holder must inform staff of the change in the risk reduction plan and document that staff were informed of the change.

**EFFECTIVE DATE.** This section is effective September 30, 2019.

Sec. 98. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision to read:

Subd. 8. **Required policies.** A certified center must have written policies for health and safety items in subdivisions 1 to 6.

**EFFECTIVE DATE.** This section is effective September 30, 2019.

Sec. 99. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision to read:

Subd. 9. **Behavior guidance.** The certified center must ensure that staff and volunteers use positive behavior guidance and do not subject children to:

(1) corporal punishment, including but not limited to rough handling, shoving, hair pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking;

(2) humiliation;

(3) abusive language;

(4) the use of mechanical restraints, including tying;

(5) the use of physical restraints other than to physically hold a child when containment is necessary to protect a child or others from harm; or

(6) the withholding or forcing of food and other basic needs.

**EFFECTIVE DATE.** This section is effective September 30, 2019.

Sec. 100. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision to read:

Subd. 10. **Supervision.** Staff must supervise each child at all times. Staff are responsible for the ongoing activity of each child, appropriate visual or auditory awareness, physical proximity, and knowledge of activity requirements and each child's needs. Staff must intervene when necessary to ensure a child's safety. In determining the appropriate level of supervision of a child, staff must consider: (1) the age of a child; (2) individual differences and abilities; (3) indoor and outdoor layout of the child care program; and (4) environmental circumstances, hazards, and risks.

**EFFECTIVE DATE.** This section is effective September 30, 2019.

Sec. 101. Minnesota Statutes 2018, section 245H.14, subdivision 1, is amended to read:

Subdivision 1. **First aid and cardiopulmonary resuscitation.** ~~At least one designated staff person who completed pediatric first aid training and pediatric cardiopulmonary resuscitation (CPR) training must be present at all times at the program, during field trips, and when transporting a child. The designated staff person must repeat pediatric first aid training and pediatric CPR training at least once every two years.~~

(a) Before having unsupervised direct contact with a child, but within the first 90 days of employment for the director and all staff persons, and within 90 days after the first date of direct contact with a child for substitutes and unsupervised volunteers, each person must successfully complete pediatric first aid and pediatric cardiopulmonary resuscitation (CPR) training, unless the training has been completed within the previous two calendar years. Staff must complete the pediatric first aid and pediatric CPR training at least every other calendar year and the center must document the training in the staff person's personnel record.

(b) Training completed under this subdivision may be used to meet the in-service training requirements under subdivision 6.

**EFFECTIVE DATE.** This section is effective September 30, 2019.

Sec. 102. Minnesota Statutes 2018, section 245H.14, subdivision 3, is amended to read:

Subd. 3. **Abusive head trauma.** A certified center that cares for a child ~~through four years of age~~ under school age must ensure that the director and all staff persons ~~and volunteers~~, including substitutes and unsupervised volunteers, receive training on abusive

head trauma ~~from shaking infants and young children~~ before assisting in the care of a child ~~through four years of age~~ under school age.

**EFFECTIVE DATE.** This section is effective September 30, 2019.

Sec. 103. Minnesota Statutes 2018, section 245H.14, subdivision 4, is amended to read:

Subd. 4. **Child development.** The certified center must ensure ~~each staff person completes at least two hours of~~ that the director and all staff persons complete child development and learning training within ~~14~~ 90 days of employment and ~~annually~~ every second calendar year thereafter. Substitutes and unsupervised volunteers must complete child development and learning training within 90 days after the first date of direct contact with a child and every second calendar year thereafter. The director and staff persons not including substitutes must complete at least two hours of training on child development. The training for substitutes and unsupervised volunteers is not required to be of a minimum length. For purposes of this subdivision, "child development and learning training" means how a child develops physically, cognitively, emotionally, and socially and learns as part of the child's family, culture, and community.

**EFFECTIVE DATE.** This section is effective September 30, 2019.

Sec. 104. Minnesota Statutes 2018, section 245H.14, subdivision 5, is amended to read:

Subd. 5. **Orientation.** The certified center must ensure ~~each staff person is~~ the director and all staff persons, substitutes, and unsupervised volunteers are trained at orientation on health and safety requirements in sections 245H.11, 245H.13, 245H.14, and 245H.15. The certified center must provide ~~staff with an~~ orientation within 14 days ~~of employment~~ after the first date of direct contact with a child. Before the completion of orientation, ~~a staff person~~ these individuals must be supervised while providing direct care to a child.

**EFFECTIVE DATE.** This section is effective September 30, 2019.

Sec. 105. Minnesota Statutes 2018, section 245H.14, subdivision 6, is amended to read:

Subd. 6. **In service.** (a) The certified center must ensure ~~each~~ that the director and all staff ~~person is~~ persons, including substitutes and unsupervised volunteers, are trained at least ~~annually~~ once each calendar year on health and safety requirements in sections 245H.11, 245H.13, 245H.14, and 245H.15.

(b) The director and each staff person, not including substitutes, must ~~annually~~ complete at least six hours of training each calendar year. Training required under paragraph (a) may be used toward the hourly training requirements of this subdivision.

**EFFECTIVE DATE.** This section is effective September 30, 2019.

Sec. 106. Minnesota Statutes 2018, section 245H.15, subdivision 1, is amended to read:

Subdivision 1. **Written emergency plan.** (a) A certified center must have a written emergency plan for emergencies that require evacuation, sheltering, or other protection of children, such as fire, natural disaster, intruder, or other threatening situation that may pose a health or safety hazard to children. The plan must be written on a form developed by the commissioner and reviewed and updated at least once each calendar year. The annual review of the emergency plan must be documented.

(b) The plan must include:

(1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

(2) a designated relocation site and evacuation route;

(3) procedures for notifying a child's parent or legal guardian of the relocation and reunification with families;

(4) accommodations for a child with a disability or a chronic medical condition;

(5) procedures for storing a child's medically necessary medicine that facilitates easy removal during an evacuation or relocation;

(6) procedures for continuing operations in the period during and after a crisis; ~~and~~

(7) procedures for communicating with local emergency management officials, law enforcement officials, or other appropriate state or local authorities~~.~~; and

(8) accommodations for infants and toddlers.

(c) The certification holder must have an emergency plan available for review upon request by the child's parent or legal guardian.

**EFFECTIVE DATE.** This section is effective September 30, 2019.

Sec. 107. Minnesota Statutes 2018, section 256.046, subdivision 1, is amended to read:

Subdivision 1. **Hearing authority.** A local agency must initiate an administrative fraud disqualification hearing for individuals~~, including child care providers caring for children receiving child care assistance,~~ accused of wrongfully obtaining assistance or intentional

program violations, in lieu of a criminal action when it has not been pursued, in the Minnesota family investment program and any affiliated program to include the diversionary work program and the work participation cash benefit program, child care assistance programs, general assistance, family general assistance program formerly codified in section 256D.05, subdivision 1, clause (15), Minnesota supplemental aid, food stamp programs, MinnesotaCare for adults without children, and upon federal approval, all categories of medical assistance and remaining categories of MinnesotaCare except for children through age 18. The Department of Human Services, in lieu of a local agency, may initiate an administrative fraud disqualification hearing when the state agency is directly responsible for administration or investigation of the program for which benefits were wrongfully obtained. The hearing is subject to the requirements of ~~section~~ sections 256.045 and 256.0451 and the requirements in Code of Federal Regulations, title 7, section 273.16.

Sec. 108. Minnesota Statutes 2018, section 256.046, is amended by adding a subdivision to read:

Subd. 3. **Administrative disqualification of child care providers caring for children receiving child care assistance.** (a) The department or local agency shall pursue an administrative disqualification, if the child care provider is accused of committing an intentional program violation, in lieu of a criminal action when it has not been pursued. Intentional program violations include intentionally making false or misleading statements; intentionally misrepresenting, concealing, or withholding facts; and repeatedly and intentionally violating program regulations under chapters 119B and 245E. Intent may be proven by demonstrating a pattern of conduct that violates program rules under chapters 119B and 245E.

(b) To initiate an administrative disqualification, a local agency or the commissioner must mail written notice to the provider against whom the action is being taken. Unless otherwise specified under chapter 119B or 245E or Minnesota Rules, chapter 3400, a local agency or the commissioner must mail the written notice at least 15 calendar days before the adverse action's effective date. The notice shall state (1) the factual basis for the agency's determination, (2) the action the agency intends to take, (3) the dollar amount of the monetary recovery or recoupment, if known, and (4) the provider's right to appeal the agency's proposed action.

(c) The provider may appeal an administrative disqualification by submitting a written request to the Department of Human Services, Appeals Division. A provider's request must

be received by the Appeals Division no later than 30 days after the date a local agency or the commissioner mails the notice.

(d) The provider's appeal request must contain the following:

(1) each disputed item, the reason for the dispute, and, if applicable, an estimate of the dollar amount involved for each disputed item;

(2) the computation the provider believes to be correct, if applicable;

(3) the statute or rule relied on for each disputed item; and

(4) the name, address, and telephone number of the person at the provider's place of business with whom contact may be made regarding the appeal.

(e) On appeal, the issuing agency bears the burden of proof to demonstrate by a preponderance of the evidence that the provider committed an intentional program violation.

(f) The hearing is subject to the requirements of sections 256.045 and 256.0451. The human services judge may combine a fair hearing and administrative disqualification hearing into a single hearing if the factual issues arise out of the same or related circumstances and the provider receives prior notice that the hearings will be combined.

(g) A provider found to have committed an intentional program violation and is administratively disqualified shall be disqualified, for a period of three years for the first offense and permanently for any subsequent offense, from receiving any payments from any child care program under chapter 119B.

(h) Unless a timely and proper appeal made under this section is received by the department, the administrative determination of the department is final and binding.

Sec. 109. Minnesota Statutes 2018, section 256.98, subdivision 8, is amended to read:

Subd. 8. **Disqualification from program.** (a) Any person found to be guilty of wrongfully obtaining assistance by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, in the Minnesota family investment program and any affiliated program to include the diversionary work program and the work participation cash benefit program, the food stamp or food support program, the general assistance program, housing support under chapter 256I, or the Minnesota supplemental aid program shall be disqualified from that program. In addition, any person disqualified from the Minnesota family investment program shall also be disqualified from the food

stamp or food support program. The needs of that individual shall not be taken into consideration in determining the grant level for that assistance unit:

(1) for one year after the first offense;

(2) for two years after the second offense; and

(3) permanently after the third or subsequent offense.

The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved. A disqualification established through hearing or waiver shall result in the disqualification period beginning immediately unless the person has become otherwise ineligible for assistance. If the person is ineligible for assistance, the disqualification period begins when the person again meets the eligibility criteria of the program from which they were disqualified and makes application for that program.

(b) A family receiving assistance through child care assistance programs under chapter 119B with a family member who is found to be guilty of wrongfully obtaining child care assistance by a federal court, state court, or an administrative hearing determination or waiver, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions, is disqualified from child care assistance programs. The disqualifications must be for periods of one year and two years for the first and second offenses, respectively. Subsequent violations must result in permanent disqualification. During the disqualification period, disqualification from any child care program must extend to all child care programs and must be immediately applied.

(c) A provider caring for children receiving assistance through child care assistance programs under chapter 119B is disqualified from receiving payment for child care services from the child care assistance program under chapter 119B when the provider is found to have wrongfully obtained child care assistance by a federal court, state court, or an administrative hearing determination or waiver under section 256.046, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions. The disqualification

must be for a period of ~~one year~~ three years for the first offense ~~and two years for the second offense~~. Any subsequent violation must result in permanent disqualification. The disqualification period must be imposed immediately after a determination is made under this paragraph. During the disqualification period, the provider is disqualified from receiving payment from any child care program under chapter 119B.

(d) Any person found to be guilty of wrongfully obtaining MinnesotaCare for adults without children and upon federal approval, all categories of medical assistance and remaining categories of MinnesotaCare, except for children through age 18, by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, is disqualified from that program. The period of disqualification is one year after the first offense, two years after the second offense, and permanently after the third or subsequent offense. The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved.

Sec. 110. Minnesota Statutes 2018, section 256B.02, subdivision 7, is amended to read:

Subd. 7. **Vendor of medical care.** (a) "Vendor of medical care" means any person or persons furnishing, within the scope of the vendor's respective license, any or all of the following goods or services: medical, surgical, hospital, ambulatory surgical center services, optical, visual, dental and nursing services; drugs and medical supplies; appliances; laboratory, diagnostic, and therapeutic services; nursing home and convalescent care; screening and health assessment services provided by public health nurses as defined in section 145A.02, subdivision 18; health care services provided at the residence of the patient if the services are performed by a public health nurse and the nurse indicates in a statement submitted under oath that the services were actually provided; and such other ~~medical~~ services or supplies provided or prescribed by persons authorized by state law to give such services and supplies. The term includes, but is not limited to, directors and officers of corporations or members of partnerships who, either individually or jointly with another or others, have the legal control, supervision, or responsibility of submitting claims for reimbursement to the medical assistance program. The term only includes directors and

officers of corporations who personally receive a portion of the distributed assets upon liquidation or dissolution, and their liability is limited to the portion of the claim that bears the same proportion to the total claim as their share of the distributed assets bears to the total distributed assets.

(b) "Vendor of medical care" also includes any person who is credentialed as a health professional under standards set by the governing body of a federally recognized Indian tribe authorized under an agreement with the federal government according to United States Code, title 25, section 450f, to provide health services to its members, and who through a tribal facility provides covered services to American Indian people within a contract health service delivery area of a Minnesota reservation, as defined under Code of Federal Regulations, title 42, section 36.22.

(c) A federally recognized Indian tribe that intends to implement standards for credentialing health professionals must submit the standards to the commissioner of human services, along with evidence of meeting, exceeding, or being exempt from corresponding state standards. The commissioner shall maintain a copy of the standards and supporting evidence, and shall use those standards to enroll tribal-approved health professionals as medical assistance providers. For purposes of this section, "Indian" and "Indian tribe" mean persons or entities that meet the definition in United States Code, title 25, section 450b.

Sec. 111. Minnesota Statutes 2018, section 256B.064, subdivision 1a, is amended to read:

Subd. 1a. **Grounds for sanctions against vendors.** The commissioner may impose sanctions against a vendor of medical care for any of the following: (1) fraud, theft, or abuse in connection with the provision of medical care to recipients of public assistance; (2) a pattern of presentment of false or duplicate claims or claims for services not medically necessary; (3) a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the vendor is legally entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally established under this section; (7) failure to correct errors in the maintenance of health service or financial records for which a fine was imposed or after issuance of a warning by the commissioner; ~~and~~ (8) any reason for which a vendor could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act~~.~~; and (9) there is a preponderance of

the evidence that the vendor committed an act or acts that meet the definition of offenses listed in section 609.817.

Sec. 112. Minnesota Statutes 2018, section 256B.064, subdivision 1b, is amended to read:

Subd. 1b. **Sanctions available.** The commissioner may impose the following sanctions for the conduct described in subdivision 1a: suspension or withholding of payments to a vendor and suspending or terminating participation in the program, or imposition of a fine under subdivision 2, paragraph (f). When imposing sanctions under this section, the commissioner shall consider the nature, chronicity, or severity of the conduct and the effect of the conduct on the health and safety of persons served by the vendor. The commissioner shall suspend a vendor's participation in the program for a minimum of five years if, for an offense related to a provision of a health service under medical assistance or health care fraud, the vendor is convicted of a crime, received a stay of adjudication, or entered a court-ordered diversion program. Regardless of imposition of sanctions, the commissioner may make a referral to the appropriate state licensing board.

Sec. 113. Minnesota Statutes 2018, section 256B.064, subdivision 2, is amended to read:

Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner shall determine any monetary amounts to be recovered and sanctions to be imposed upon a vendor of medical care under this section. Except as provided in paragraphs (b) and (d), neither a monetary recovery nor a sanction will be imposed by the commissioner without prior notice and an opportunity for a hearing, according to chapter 14, on the commissioner's proposed action, provided that the commissioner may suspend or reduce payment to a vendor of medical care, except a nursing home or convalescent care facility, after notice and prior to the hearing if in the commissioner's opinion that action is necessary to protect the public welfare and the interests of the program.

(b) Except when the commissioner finds good cause not to suspend payments under Code of Federal Regulations, title 42, section 455.23 (e) or (f), the commissioner shall withhold or reduce payments to a vendor of medical care without providing advance notice of such withholding or reduction if either of the following occurs:

(1) the vendor is convicted of a crime involving the conduct described in subdivision 1a; or

(2) the commissioner determines there is a credible allegation of fraud for which an investigation is pending under the program. A credible allegation of fraud is an allegation which has been verified by the state, from any source, including but not limited to:

(i) fraud hotline complaints;

(ii) claims data mining; and

(iii) patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Allegations are considered to be credible when they have an indicia of reliability and the state agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

(c) The commissioner must send notice of the withholding or reduction of payments under paragraph (b) within five days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold the notice. The notice must:

(1) state that payments are being withheld according to paragraph (b);

(2) set forth the general allegations as to the nature of the withholding action, but need not disclose any specific information concerning an ongoing investigation;

(3) except in the case of a conviction for conduct described in subdivision 1a, state that the withholding is for a temporary period and cite the circumstances under which withholding will be terminated;

(4) identify the types of claims to which the withholding applies; and

(5) inform the vendor of the right to submit written evidence for consideration by the commissioner.

The withholding or reduction of payments will not continue after the commissioner determines there is insufficient evidence of fraud by the vendor, or after legal proceedings relating to the alleged fraud are completed, unless the commissioner has sent notice of intention to impose monetary recovery or sanctions under paragraph (a). Upon conviction for a crime related to the provision, management, or administration of a health service under medical assistance, a payment held pursuant to this section by the commissioner or a managed care organization that contracts with the commissioner under section 256B.035 is forfeited by the commissioner or managed care organization, regardless of the amount charged in the criminal complaint or the amount of criminal restitution ordered.

(d) The commissioner shall suspend or terminate a vendor's participation in the program without providing advance notice and an opportunity for a hearing when the suspension or termination is required because of the vendor's exclusion from participation in Medicare.

Within five days of taking such action, the commissioner must send notice of the suspension or termination. The notice must:

(1) state that suspension or termination is the result of the vendor's exclusion from Medicare;

(2) identify the effective date of the suspension or termination; and

(3) inform the vendor of the need to be reinstated to Medicare before reapplying for participation in the program.

(e) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction is to be imposed, a vendor may request a contested case, as defined in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The appeal request must be received by the commissioner no later than 30 days after the date the notification of monetary recovery or sanction was mailed to the vendor. The appeal request must specify:

(1) each disputed item, the reason for the dispute, and an estimate of the dollar amount involved for each disputed item;

(2) the computation that the vendor believes is correct;

(3) the authority in statute or rule upon which the vendor relies for each disputed item;

(4) the name and address of the person or entity with whom contacts may be made regarding the appeal; and

(5) other information required by the commissioner.

(f) The commissioner may order a vendor to forfeit a fine for failure to fully document services according to standards in this chapter and Minnesota Rules, chapter 9505. The commissioner may assess fines if specific required components of documentation are missing. The fine for incomplete documentation shall equal 20 percent of the amount paid on the claims for reimbursement submitted by the vendor, or up to $5,000, whichever is less. If the commissioner determines that a vendor repeatedly violated this chapter or Minnesota Rules, chapter 9505, related to the provision of services to program recipients and the submission of claims for payment, the commissioner may order a vendor to forfeit a fine based on the nature, severity, and chronicity of the violations in an amount of up to $5,000 or 20 percent of the value of the claims, whichever is greater.

(g) The vendor shall pay the fine assessed on or before the payment date specified. If the vendor fails to pay the fine, the commissioner may withhold or reduce payments and

recover the amount of the fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

Sec. 114. Minnesota Statutes 2018, section 256B.064, is amended by adding a subdivision to read:

Subd. 3. **Vendor mandates on prohibited payments.** (a) The commissioner shall maintain and publish a list of each excluded individual and entity that was convicted of a crime related to the provision, management, or administration of a medical assistance health service, or suspended or terminated under subdivision 2. Medical assistance payments cannot be made by a vendor for items or services furnished either directly or indirectly by an excluded individual or entity, or at the direction of excluded individuals or entities.

(b) The vendor must check the exclusion list on a monthly basis and document the date and time the exclusion list was checked and the name and title of the person who checked the exclusion list. The vendor must immediately terminate payments to an individual or entity on the exclusion list.

(c) A vendor's requirement to check the exclusion list and to terminate payments to individuals or entities on the exclusion list applies to each individual or entity on the exclusion list, even if the named individual or entity is not responsible for direct patient care or direct submission of a claim to medical assistance.

(d) A vendor that pays medical assistance program funds to an individual or entity on the exclusion list must refund any payment related to either items or services rendered by an individual or entity on the exclusion list from the date the individual or entity is first paid or the date the individual or entity is placed on the exclusion list, whichever is later, and a vendor may be subject to:

(1) sanctions under subdivision 2;

(2) a civil monetary penalty of up to $25,000 for each determination by the department that the vendor employed or contracted with an individual or entity on the exclusion list; and

(3) other fines or penalties allowed by law.

Sec. 115. Minnesota Statutes 2018, section 256B.064, is amended by adding a subdivision to read:

Subd. 4. **Notice.** (a) The notice required under subdivision 2 shall be served by first class mail at the address submitted to the department by the vendor. Service is complete upon

mailing. The commissioner shall place an affidavit of the first class mailing in the vendor's file as an indication of the address and the date of mailing.

(b) The department shall give notice in writing to a recipient placed in the Minnesota restricted recipient program under section 256B.0646 and Minnesota Rules, part 9505.2200. The notice shall be sent by first class mail to the recipient's current address on file with the department. A recipient placed in the Minnesota restricted recipient program may contest the placement by submitting a written request for a hearing to the department within 90 days of the notice being mailed.

Sec. 116. Minnesota Statutes 2018, section 256B.064, is amended by adding a subdivision to read:

Subd. 5. **Immunity; good faith reporters.** (a) A person who makes a good faith report is immune from any civil or criminal liability that might otherwise arise from reporting or participating in the investigation. Nothing in this subdivision affects a vendor's responsibility for an overpayment established under this subdivision.

(b) A person employed by a lead investigative agency who is conducting or supervising an investigation or enforcing the law according to the applicable law or rule is immune from any civil or criminal liability that might otherwise arise from the person's actions, if the person is acting in good faith and exercising due care.

(c) For purposes of this subdivision, "person" includes a natural person or any form of a business or legal entity.

(d) After an investigation is complete, the reporter's name must be kept confidential. The subject of the report may compel disclosure of the reporter's name only with the consent of the reporter or upon a written finding by a district court that the report was false and there is evidence that the report was made in bad faith. This subdivision does not alter disclosure responsibilities or obligations under the Rules of Criminal Procedure, except that when the identity of the reporter is relevant to a criminal prosecution the district court shall conduct an in-camera review before determining whether to order disclosure of the reporter's identity.

Sec. 117. **[256B.0646] MINNESOTA RESTRICTED RECIPIENT PROGRAM; PERSONAL CARE ASSISTANCE SERVICES.**

(a) When a recipient's use of personal care assistance services or community first services and supports under section 256B.85 results in abusive or fraudulent billing, the commissioner may place a recipient in the Minnesota restricted recipient program under Minnesota Rules,

part 9505.2165. A recipient placed in the Minnesota restricted recipient program under this section must: (1) use a designated traditional personal care assistance provider agency; and (2) obtain a new assessment under section 256B.0911, including consultation with a registered or public health nurse on the long-term care consultation team pursuant to section 256B.0911, subdivision 3, paragraph (b), clause (2).

(b) A recipient must comply with additional conditions for the use of personal care assistance services or community first services and supports if the commissioner determines it is necessary to prevent future misuse of personal care assistance services or abusive or fraudulent billing. Additional conditions may include but are not limited to restricting service authorizations for a duration of no more than one month and requiring a qualified professional to monitor and report services on a monthly basis.

(c) A recipient placed in the Minnesota restricted recipient program under this section may appeal the placement according to section 256.045.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 118. Minnesota Statutes 2018, section 256B.0651, subdivision 17, is amended to read:

Subd. 17. **Recipient protection.** (a) Providers of home care services must provide each recipient with a copy of the home care bill of rights under section 144A.44 at least 30 days prior to terminating services to a recipient, if the termination results from provider sanctions under section 256B.064, such as a payment withhold, a suspension of participation, or a termination of participation. If a home care provider determines it is unable to continue providing services to a recipient, the provider must notify the recipient, the recipient's responsible party, and the commissioner 30 days prior to terminating services to the recipient because of an action under section 256B.064, and must assist the commissioner and lead agency in supporting the recipient in transitioning to another home care provider of the recipient's choice.

(b) In the event of a payment withhold from a home care provider, a suspension of participation, or a termination of participation of a home care provider under section 256B.064, the commissioner may inform the Office of Ombudsman for Long-Term Care and the lead agencies for all recipients with active service agreements with the provider. At the commissioner's request, the lead agencies must contact recipients to ensure that the recipients are continuing to receive needed care, and that the recipients have been given free choice of provider if they transfer to another home care provider. In addition, the commissioner or the commissioner's delegate may directly notify recipients who receive

care from the provider that payments have been or will be withheld or that the provider's participation in medical assistance has been or will be suspended or terminated, if the commissioner determines that notification is necessary to protect the welfare of the recipients. For purposes of this subdivision, "lead agencies" means counties, tribes, and managed care organizations.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 119. Minnesota Statutes 2018, section 256B.0659, subdivision 12, is amended to read:

Subd. 12. **Documentation of personal care assistance services provided.** (a) Personal care assistance services for a recipient must be documented daily by each personal care assistant, on a time sheet form approved by the commissioner. All documentation may be web-based, electronic, or paper documentation. The completed form must be submitted on a monthly basis to the provider and kept in the recipient's health record.

(b) The activity documentation must correspond to the personal care assistance care plan and be reviewed by the qualified professional.

(c) The personal care assistant time sheet must be on a form approved by the commissioner documenting time the personal care assistant provides services in the home. The following criteria must be included in the time sheet:

(1) full name of personal care assistant and individual provider number;

(2) provider name and telephone numbers;

(3) full name of recipient and either the recipient's medical assistance identification number or date of birth;

(4) consecutive dates, including month, day, and year, and arrival and departure times with a.m. or p.m. notations;

(5) signatures of recipient or the responsible party;

(6) personal signature of the personal care assistant;

(7) any shared care provided, if applicable;

(8) a statement that it is a federal crime to provide false information on personal care service billings for medical assistance payments; and

(9) dates and location of recipient stays in a hospital, care facility, or incarceration.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 120. Minnesota Statutes 2018, section 256B.27, subdivision 3, is amended to read:

Subd. 3. **Access to medical records.** The commissioner of human services, with the written consent of the recipient, on file with the local welfare agency, shall be allowed access to all personal medical records of medical assistance recipients solely for the purposes of investigating whether or not: (a) a vendor of medical care has submitted a claim for reimbursement, a cost report or a rate application which is duplicative, erroneous, or false in whole or in part, or which results in the vendor obtaining greater compensation than the vendor is legally entitled to; or (b) the medical care was medically necessary. ~~The vendor of medical care shall receive notification from the commissioner at least 24 hours before the commissioner gains access to such records.~~ When the commissioner is investigating a possible overpayment of Medicaid funds, the commissioner must be given immediate access without prior notice to the vendor's office during regular business hours and to documentation and records related to services provided and submission of claims for services provided. Denying the commissioner access to records is cause for the vendor's immediate suspension of payment or termination according to section 256B.064. The determination of provision of services not medically necessary shall be made by the commissioner. Notwithstanding any other law to the contrary, a vendor of medical care shall not be subject to any civil or criminal liability for providing access to medical records to the commissioner of human services pursuant to this section.

Sec. 121. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision to read:

Subd. 11. **Home and community-based service billing requirements.** (a) A home and community-based service is eligible for reimbursement if:

(1) the service is provided according to a federally approved waiver plan as authorized under sections 256B.0913, 256B.0915, 256B.092, and 256B.49;

(2) if applicable, the service is provided on days and times during the days and hours of operation specified on any license required under chapter 245A or 245D; and

(3) the provider complies with subdivisions 12 to 15, if applicable.

(b) The provider must maintain documentation that, upon employment and annually thereafter, staff providing a service have attested to reviewing and understanding the following statement: "It is a federal crime to provide materially false information on service billings for medical assistance or services provided under a federally approved waiver plan

as authorized under Minnesota Statutes, sections 256B.0913, 256B.0915, 256B.092, and 256B.49."

(c) The department may recover payment according to section 256B.064 and Minnesota Rules, parts 9505.2160 to 9505.2245, for a service that does not satisfy this subdivision.

Sec. 122. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision to read:

Subd. 12. **Home and community-based service documentation requirements.** (a) Documentation may be collected and maintained electronically or in paper form by providers and must be produced upon request by the commissioner.

(b) Documentation of a delivered service must be in English and must be legible according to the standard of a reasonable person.

(c) If the service is reimbursed at an hourly or specified minute-based rate, each documentation of the provision of a service, unless otherwise specified, must include:

(1) the date the documentation occurred;

(2) the day, month, and year when the service was provided;

(3) the start and stop times with a.m. and p.m. designations, except for case management services as defined under sections 256B.0913, subdivision 7; 256B.0915, subdivision 1a; 256B.092, subdivision 1a; and 256B.49, subdivision 13;

(4) the service name or description of the service provided; and

(5) the name, signature, and title, if any, of the provider of service. If the service is provided by multiple staff members, the provider may designate a staff member responsible for verifying services and completing the documentation required by this paragraph.

(d) If the service is reimbursed at a daily rate or does not meet the requirements in paragraph (c), each documentation of the provision of a service, unless otherwise specified, must include:

(1) the date the documentation occurred;

(2) the day, month, and year when the service was provided;

(3) the service name or description of the service provided; and

(4) the name, signature, and title, if any, of the person providing the service. If the service is provided by multiple staff, the provider may designate a staff member responsible for verifying services and completing the documentation required by this paragraph.

Sec. 123. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision to read:

Subd. 13. **Waiver transportation documentation and billing requirements.** (a) A waiver transportation service must be a waiver transportation service that: (1) is not covered by medical transportation under the Medicaid state plan; and (2) is not included as a component of another waiver service.

(b) In addition to the documentation requirements in subdivision 12, a waiver transportation service provider must maintain:

(1) odometer and other records pursuant to section 256B.0625, subdivision 17b, paragraph (b), clause (3), sufficient to distinguish an individual trip with a specific vehicle and driver for a waiver transportation service that is billed directly by the mile. A common carrier as defined by Minnesota Rules, part 9505.0315, subpart 1, item B, or a publicly operated transit system provider are exempt from this clause; and

(2) documentation demonstrating that a vehicle and a driver meet the standards determined by the Department of Human Services on vehicle and driver qualifications in section 256B.0625, subdivision 17, paragraph (c).

Sec. 124. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision to read:

Subd. 14. **Equipment and supply documentation requirements.** (a) In addition to the requirements in subdivision 12, an equipment and supply services provider must for each documentation of the provision of a service include:

(1) the recipient's assessed need for the equipment or supply;

(2) the reason the equipment or supply is not covered by the Medicaid state plan;

(3) the type and brand name of the equipment or supply delivered to or purchased by the recipient, including whether the equipment or supply was rented or purchased;

(4) the quantity of the equipment or supply delivered or purchased; and

(5) the cost of the equipment or supply if the amount paid for the service depends on the cost.

(b) A provider must maintain a copy of the shipping invoice or a delivery service tracking log or other documentation showing the date of delivery that proves the equipment or supply was delivered to the recipient or a receipt if the equipment or supply was purchased by the recipient.

Sec. 125. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision to read:

Subd. 15. **Adult day service documentation and billing requirements.** (a) In addition to the requirements in subdivision 12, a provider of adult day services as defined in section 245A.02, subdivision 2a, and licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, must maintain documentation of:

(1) a needs assessment and current plan of care according to section 245A.143, subdivisions 4 to 7, or Minnesota Rules, part 9555.9700, for each recipient, if applicable;

(2) attendance records as specified under section 245A.14, subdivision 14, paragraph (c), including the date of attendance with the day, month, and year; and the pickup and drop-off time in hours and minutes with a.m. and p.m. designations;

(3) the monthly and quarterly program requirements in Minnesota Rules, part 9555.9710, subparts 1, items E and H; 3; 4; and 6, if applicable;

(4) the name and qualification of each registered physical therapist, registered nurse, and registered dietitian who provides services to the adult day services or nonresidential program; and

(5) the location where the service was provided. If the location is an alternate location from the usual place of service, the documentation must include the address, or a description if the address is not available, of both the origin site and destination site; the length of time at the alternate location with a.m. and p.m. designations; and a list of participants who went to the alternate location.

(b) A provider must not exceed the provider's licensed capacity. If a provider exceeds the provider's licensed capacity, the department must recover all Minnesota health care programs payments from the date the provider exceeded licensed capacity.

**EFFECTIVE DATE.** This section is effective August 1, 2019.

Sec. 126. **[609.817] CRIMINAL PENALTIES FOR ACTS INVOLVING HUMAN SERVICES PROGRAMS.**

Subdivision 1. **Prohibited payments made relating to human services programs.** A person is in violation of this section if the person knowingly and willfully offers or pays any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, to another person:

(1) to induce that person to apply for, receive, or induce another person to apply for or receive an item or service for which payment may be made in whole or in part by a local social services agency as defined in chapter 393 or by the Department of Human Services, or administered by the commissioner of human services; or

(2) in return for purchasing, leasing, ordering, or arranging for or inducing the purchasing, leasing, or ordering of any good, facility, service, or item for which payment may be made in whole or in part, or which is administered in whole or in part by a local social services agency as defined in chapter 393, the Department of Human Services, or the United States Department of Health and Human Services.

Subd. 2. **Receipt of prohibited payments relating to human services programs.** A person is in violation of this section if the person knowingly and willfully solicits or receives any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind:

(1) in return for applying for or receiving a human services benefit, service, or grant for which payment may be made in whole or in part by a local services agency as defined in chapter 393 or the Department of Human Services, or is administered by the commissioner of human services; or

(2) in return for purchasing, leasing, ordering, or arranging for or inducing the purchasing, leasing, or ordering of any good, facility, service, or item for which payment may be made in whole or in part, or which is administered in whole or in part, by the Department of Human Services, a local social services agency as defined in chapter 393, or the United States Department of Health and Human Services.

Subd. 3. **Payments exempt.** This section does not apply to remuneration exempted from the Anti-Kickback Statute under United States Code, title 42, section 1320a-7b(b)(3), or remuneration excepted from liability by Code of Federal Regulations, title 42, section 1001.952.

Subd. 4. **Penalties.** (a) A person who violates subdivision 1 or 2 may be sentenced according to section 609.52, subdivision 3.

(1) For a violation of subdivision 1, for the purposes of sentencing under section 609.52, subdivision 3, the calculated value is equal to the value of the good, facility, service, or item that was obtained as a direct or indirect result of the prohibited payment.

(2) For a violation of subdivision 2, for the purposes of sentencing under section 609.52, subdivision 3, the calculated value is equal to the value of the prohibited payment solicited or received in violation of subdivision 2.

(b) A claim for any good, facility, service, or item rendered or claimed to have been rendered in violation of this section is noncompensable and unenforceable at the time the claim is made.

Subd. 5. **Aggregation.** In any prosecution under this section, the value of the money or property or services received by the defendant within any six-month period may be aggregated and the defendant charged accordingly in applying the provisions of subdivision 6.

Subd. 6. **Venue.** Notwithstanding section 627.01, an offense committed under this section may be prosecuted in the county where any part of the offense occurred, provided that when two or more offenses are committed by the same person in two or more counties, the accused may be prosecuted in any county in which one of the offenses was committed for all of the offenses aggregated under this subdivision.

Subd. 7. **False claims.** In addition to the penalties provided for in this section, a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of section 15C.02.

Subd. 8. **Actual knowledge or specific intent not required.** With respect to a violation of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.

Sec. 127. Minnesota Statutes 2018, section 628.26, is amended to read:

**628.26 LIMITATIONS.**

(a) Indictments or complaints for any crime resulting in the death of the victim may be found or made at any time after the death of the person killed.

(b) Indictments or complaints for a violation of section 609.25 may be found or made at any time after the commission of the offense.

(c) Indictments or complaints for violation of section 609.282 may be found or made at any time after the commission of the offense if the victim was under the age of 18 at the time of the offense.

(d) Indictments or complaints for violation of section 609.282 where the victim was 18 years of age or older at the time of the offense, or 609.42, subdivision 1, clause (1) or (2),

shall be found or made and filed in the proper court within six years after the commission of the offense.

(e) Indictments or complaints for violation of sections 609.322 and 609.342 to 609.345, if the victim was under the age of 18 years at the time the offense was committed, shall be found or made and filed in the proper court within the later of nine years after the commission of the offense or three years after the offense was reported to law enforcement authorities.

(f) Notwithstanding the limitations in paragraph (e), indictments or complaints for violation of sections 609.322 and 609.342 to 609.344 may be found or made and filed in the proper court at any time after commission of the offense, if physical evidence is collected and preserved that is capable of being tested for its DNA characteristics. If this evidence is not collected and preserved and the victim was 18 years old or older at the time of the offense, the prosecution must be commenced within nine years after the commission of the offense.

(g) Indictments or complaints for violation of sections 609.466 and 609.52, subdivision 2, paragraph (a), clause (3), item (iii), and 609.817, shall be found or made and filed in the proper court within six years after the commission of the offense.

(h) Indictments or complaints for violation of section 609.2335, 609.52, subdivision 2, clause (3), items (i) and (ii), (4), (15), or (16), 609.631, or 609.821, where the value of the property or services stolen is more than $35,000, or for violation of section 609.527 where the offense involves eight or more direct victims or the total combined loss to the direct and indirect victims is more than $35,000, shall be found or made and filed in the proper court within five years after the commission of the offense.

(i) Except for violations relating to false material statements, representations or omissions, indictments or complaints for violations of section 609.671 shall be found or made and filed in the proper court within five years after the commission of the offense.

(j) Indictments or complaints for violation of sections 609.561 to 609.563, shall be found or made and filed in the proper court within five years after the commission of the offense.

(k) In all other cases, indictments or complaints shall be found or made and filed in the proper court within three years after the commission of the offense.

(l) The limitations periods contained in this section shall exclude any period of time during which the defendant was not an inhabitant of or usually resident within this state.

(m) The limitations periods contained in this section for an offense shall not include any period during which the alleged offender participated under a written agreement in a pretrial diversion program relating to that offense.

(n) The limitations periods contained in this section shall not include any period of time during which physical evidence relating to the offense was undergoing DNA analysis, as defined in section 299C.155, unless the defendant demonstrates that the prosecuting or law enforcement agency purposefully delayed the DNA analysis process in order to gain an unfair advantage.

Sec. 128. **REPEALER.**

(a) Minnesota Rules, parts 9502.0425, subparts 4, 16, and 17; and 9503.0155, subpart 8, are repealed.

(b) Minnesota Statutes 2018, section 245H.10, subdivision 2, is repealed.

(c) Minnesota Statutes 2018, section 119B.125, subdivision 8, is repealed.

**EFFECTIVE DATE.** This section is effective September 30, 2019.

## ARTICLE 3
## DIRECT CARE AND TREATMENT

Section 1. Minnesota Statutes 2018, section 246.54, is amended by adding a subdivision to read:

Subd. 3. **Administrative review of county liability for cost of care.** (a) The county of financial responsibility may submit a written request for administrative review by the commissioner of the county's payment of the cost of care when a delay in discharge of a client from a regional treatment center, state-operated community-based behavioral health hospital, or other state-operated facility results from the following actions by the facility:

(1) the facility did not provide notice to the county that the facility has determined that it is clinically appropriate for a client to be discharged;

(2) the notice to the county that the facility has determined that it is clinically appropriate for a client to be discharged was communicated on a holiday or weekend;

(3) the required documentation or procedures for discharge were not completed in order for the discharge to occur in a timely manner; or

(4) the facility disagrees with the county's discharge plan.

(b) The county of financial responsibility may not appeal the determination that it is clinically appropriate for a client to be discharged from a regional treatment center, state-operated community-based behavioral health hospital, or other state-operated facility.

(c) The commissioner must evaluate the request for administrative review and determine if the facility's actions listed in paragraph (a) caused undue delay in discharging the client. If the commissioner determines that the facility's actions listed in paragraph (a) caused undue delay in discharging the client, the county's liability must be reduced to the level of the cost of care for a client whose stay in a facility is determined to be clinically appropriate, effective on the date of the facility's action or failure to act that caused the delay. The commissioner's determination under this subdivision is final and not subject to appeal.

(d) If a county's liability is reduced pursuant to paragraph (c), a county's liability must return to the level of the cost of care for a client whose stay in a facility is determined to no longer be appropriate effective on the date the facility rectifies the action or failure to act that caused the delay under paragraph (a).

(e) Any difference in the county cost of care liability resulting from administrative review under this subdivision must not be billed to the client or applied to future reimbursement from the client's estate or relatives.

Sec. 2. Minnesota Statutes 2018, section 246B.10, is amended to read:

**246B.10 LIABILITY OF COUNTY; REIMBURSEMENT.**

(a) The civilly committed sex offender's county shall pay to the state a portion of the cost of care provided in the Minnesota sex offender program to a civilly committed sex offender who has legally settled in that county.

(b) A county's payment must be made from the county's own sources of revenue and payments must:

(1) equal ten percent of the cost of care, as determined by the commissioner, for each day or portion of a day that the civilly committed sex offender spends at the facility for individuals admitted to the Minnesota sex offender program before August 1, 2011; or

(2) equal 25 percent of the cost of care, as determined by the commissioner, for each day or portion of a day, that the civilly committed sex offender:

(i) spends at the facility for individuals admitted to the Minnesota sex offender program on or after August 1, 2011; or

(ii) receives services within a program operated by the Minnesota sex offender program while on provisional discharge.

(c) The county is responsible for paying the state the remaining amount if payments received by the state under this chapter exceed:

(1) 90 percent of the cost of care for individuals admitted to the Minnesota sex offender program before August 1, 2011; or

(2) 75 percent of the cost of care~~, the county is responsible for paying the state the remaining amount~~ for individuals:

(i) admitted to the Minnesota sex offender program on or after August 1, 2011; or

(ii) receiving services within a program operated by the Minnesota sex offender program while on provisional discharge.

(d) The county is not entitled to reimbursement from the civilly committed sex offender, the civilly committed sex offender's estate, or from the civilly committed sex offender's relatives, except as provided in section 246B.07.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 3. **DIRECTION TO COMMISSIONER; REPORT REQUIRED.**

No later than January 1, 2023, the commissioner of human services must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services that provides an update on county and state efforts to reduce the number of days clients spend in state-operated facilities after discharge from the facility has been determined to be clinically appropriate. The report must also include information on the fiscal impact of clinically inappropriate stays in these facilities.

Sec. 4. **DIRECTION TO COMMISSIONER; DISCHARGE COORDINATION WITH COUNTIES.**

The commissioner of human services shall consult with and seek feedback from counties across the state to develop alternative approaches for the housing of individuals provisionally discharged and discharged from direct care and treatment programs according to the provisions of Minnesota Statutes, chapter 253D, to incentivize local development of placements and supports. The approaches must consider the management of implementation costs and oversight of these individuals, and potential future financial incentives for host

counties or counties within a court district for accepting and hosting discharged individuals who the county originally committed to the program.

Sec. 5. **REPEALER.**

(a) Minnesota Statutes 2018, section 246.18, subdivisions 8 and 9, are repealed.

(b) Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 10, is repealed.

## ARTICLE 4
## CONTINUING CARE FOR OLDER ADULTS

Section 1. Minnesota Statutes 2018, section 144.0724, subdivision 4, is amended to read:

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the commissioner of health MDS assessments that conform with the assessment schedule defined by Code of Federal Regulations, title 42, section 483.20, and published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, in the Long Term Care Assessment Instrument User's Manual, version 3.0, and subsequent updates when issued by the Centers for Medicare and Medicaid Services. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, to replace or supplement the current version of the manual or document.

(b) The assessments used to determine a case mix classification for reimbursement include the following:

(1) a new admission assessment;

(2) an annual assessment which must have an assessment reference date (ARD) within 92 days of the previous assessment and the previous comprehensive assessment;

(3) a significant change in status assessment must be completed within 14 days of the identification of a significant change, whether improvement or decline, and regardless of the amount of time since the last significant change in status assessment;. Effective for rehabilitation therapy completed on or after January 1, 2020, a facility must complete a significant change in status assessment if for any reason all speech, occupational, and physical therapies have ended. The ARD of the significant change in status assessment must be the eighth day after all speech, occupational, and physical therapies have ended. The last

day on which rehabilitation therapy was furnished is considered day zero when determining the ARD for the significant change in status assessment;

(4) all quarterly assessments must have an assessment reference date (ARD) within 92 days of the ARD of the previous assessment;

(5) any significant correction to a prior comprehensive assessment, if the assessment being corrected is the current one being used for RUG classification; ~~and~~

(6) any significant correction to a prior quarterly assessment, if the assessment being corrected is the current one being used for RUG classification~~.~~; and

(7) modifications to the most recent assessment in clauses (1) to (6).

(c) In addition to the assessments listed in paragraph (b), the assessments used to determine nursing facility level of care include the following:

(1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by the Senior LinkAge Line or other organization under contract with the Minnesota Board on Aging; and

(2) a nursing facility level of care determination as provided for under section 256B.0911, subdivision 4e, as part of a face-to-face long-term care consultation assessment completed under section 256B.0911, by a county, tribe, or managed care organization under contract with the Department of Human Services.

Sec. 2. Minnesota Statutes 2018, section 144.0724, subdivision 5, is amended to read:

Subd. 5. **Short stays.** (a) A facility must submit to the commissioner of health an admission assessment for all residents who stay in the facility 14 days or less.

(b) Notwithstanding the admission assessment requirements of paragraph (a), a facility may elect to accept a short stay rate with a case mix index of 1.0 for all facility residents who stay 14 days or less in lieu of submitting an admission assessment. Facilities shall make this election annually.

(c) Nursing facilities must elect one of the options described in paragraphs (a) and (b) by reporting to the commissioner of health, as prescribed by the commissioner. The election is effective on July 1 each year.

(d) An admission assessment is not required regardless of the facility's election status when a resident is admitted to and discharged from the facility on the same day.

**EFFECTIVE DATE.** This section is effective for admissions on or after July 1, 2019.

Sec. 3. Minnesota Statutes 2018, section 144.0724, subdivision 8, is amended to read:

Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, or resident's representative, or the nursing facility or boarding care home may request that the commissioner of health reconsider the assigned reimbursement classification including any items changed during the audit process. The request for reconsideration must be submitted in writing to the commissioner within 30 days of the day the resident or the resident's representative receives the resident classification notice. The request for reconsideration must include the name of the resident, the name and address of the facility in which the resident resides, the reasons for the reconsideration, and documentation supporting the request. The documentation accompanying the reconsideration request is limited to ~~a copy of the MDS that determined the classification and other~~ documents that would support or change the MDS findings.

(b) Upon request, the nursing facility must give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the commissioner of health to support the assessment findings. The nursing facility shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information. Notwithstanding any law to the contrary, the facility may not charge a fee for providing copies of the requested documentation. If a facility fails to provide the material within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the nursing facility immediately comply with the request for information and that as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100 fine for the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues.

(c) In addition to the information required under paragraphs (a) and (b), a reconsideration request from a nursing facility must contain the following information: (i) the date the reimbursement classification notices were received by the facility; (ii) the date the classification notices were distributed to the resident or the resident's representative; and (iii) a copy of a notice sent to the resident or to the resident's representative. This notice must inform the resident or the resident's representative that a reconsideration of the resident's classification is being requested, the reason for the request, that the resident's rate will change if the request is approved by the commissioner, the extent of the change, that copies of the

facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration. If the facility fails to provide the required information listed in item (iii) with the reconsideration request, the commissioner may request that the facility provide the information within 14 calendar days. The reconsideration request must be denied if the information is then not provided, and the facility may not make further reconsideration requests on that specific reimbursement classification.

(d) Reconsideration by the commissioner must be made by individuals not involved in reviewing the assessment, audit, or reconsideration that established the disputed classification. The reconsideration must be based upon the assessment that determined the classification and upon the information provided to the commissioner under paragraphs (a) and (b). If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. Within 15 working days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect characteristics of the resident at the time of the assessment. The resident and the nursing facility or boarding care home shall be notified within five working days after the decision is made. A decision by the commissioner under this subdivision is the final administrative decision of the agency for the party requesting reconsideration.

(e) The resident classification established by the commissioner shall be the classification that applies to the resident while the request for reconsideration is pending. If a request for reconsideration applies to an assessment used to determine nursing facility level of care under subdivision 4, paragraph (c), the resident shall continue to be eligible for nursing facility level of care while the request for reconsideration is pending.

(f) The commissioner may request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

Sec. 4. Minnesota Statutes 2018, section 144A.071, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** For purposes of sections 144A.071 to 144A.073, the following terms have the meanings given them:

(a) "Attached fixtures" has the meaning given in Minnesota Rules, part 9549.0020, subpart 6.

(b) ~~"Buildings"~~ "Building" has the meaning given in ~~Minnesota Rules, part 9549.0020, subpart 7~~ section 256R.261, subdivision 4.

(c) "Capital assets" has the meaning given in section ~~256B.421, subdivision 16~~ 256R.02, subdivision 8.

(d) "Commenced construction" means that all of the following conditions were met: the final working drawings and specifications were approved by the commissioner of health; the construction contracts were let; a timely construction schedule was developed, stipulating dates for beginning, achieving various stages, and completing construction; and all zoning and building permits were applied for.

(e) "Completion date" means the date on which clearance for the construction project is issued, or if a clearance for the construction project is not required, the date on which the construction project assets are available for facility use.

(f) "Construction" means any erection, building, alteration, reconstruction, modernization, or improvement necessary to comply with the nursing home licensure rules.

(g) "Construction project" means:

(1) a capital asset addition to, or replacement of a nursing home or certified boarding care home that results in new space or the remodeling of or renovations to existing facility space; and

(2) the remodeling or renovation of existing facility space the use of which is modified as a result of the project described in clause (1). This existing space and the project described in clause (1) must be used for the functions as designated on the construction plans on completion of the project described in clause (1) for a period of not less than 24 months.

(h) "Depreciation guidelines" ~~means the most recent publication of "The Estimated Useful Lives of Depreciable Hospital Assets," issued by the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois, 60611~~ has the meaning given in section 256R.261, subdivision 9.

(i) "New licensed" or "new certified beds" means:

(1) newly constructed beds in a facility or the construction of a new facility that would increase the total number of licensed nursing home beds or certified boarding care or nursing home beds in the state; or

(2) newly licensed nursing home beds or newly certified boarding care or nursing home beds that result from remodeling of the facility that involves relocation of beds but does not result in an increase in the total number of beds, except when the project involves the upgrade of boarding care beds to nursing home beds, as defined in section 144A.073, subdivision

1. "Remodeling" includes any of the type of conversion, renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1.

~~(j) "Project construction costs" means the cost of the following items that have a completion date within 12 months before or after the completion date of the project described in item (g), clause (1):~~

~~(1) facility capital asset additions;~~

~~(2) replacements;~~

~~(3) renovations;~~

~~(4) remodeling projects;~~

~~(5) construction site preparation costs;~~

~~(6) related soft costs; and~~

~~(7) the cost of new technology implemented as part of the construction project and depreciable equipment directly identified to the project, if the construction costs for clauses (1) to (6) exceed the threshold for additions and replacements stated in section 256B.431, subdivision 16. Technology and depreciable equipment shall be included in the project construction costs unless a written election is made by the facility, to not include it in the facility's appraised value for purposes of Minnesota Rules, part 9549.0020, subpart 5. Debt incurred for purchase of technology and depreciable equipment shall be included as allowable debt for purposes of Minnesota Rules, part 9549.0060, subpart 5, items A and C, unless the written election is to not include it. Any new technology and depreciable equipment included in the project construction costs that the facility elects not to include in its appraised value and allowable debt shall be treated as provided in section 256B.431, subdivision 17, paragraph (b). Written election under this paragraph must be included in the facility's request for the rate change related to the project, and this election may not be changed.~~

~~(k) "Technology" means information systems or devices that make documentation, charting, and staff time more efficient or encourage and allow for care through alternative settings including, but not limited to, touch screens, monitors, hand-helds, swipe cards, motion detectors, pagers, telemedicine, medication dispensers, and equipment to monitor vital signs and self-injections, and to observe skin and other conditions.~~

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 5. Minnesota Statutes 2018, section 144A.071, subdivision 2, is amended to read:

Subd. 2. **Moratorium.** The commissioner of health, in coordination with the commissioner of human services, shall deny each request for new licensed or certified nursing home or certified boarding care beds except as provided in subdivision 3 or 4a, or section 144A.073. "Certified bed" means a nursing home bed or a boarding care bed certified by the commissioner of health for the purposes of the medical assistance program, under United States Code, title 42, sections 1396 et seq. Certified beds in facilities which do not allow medical assistance intake shall be deemed to be decertified for purposes of this section only.

The commissioner of human services, in coordination with the commissioner of health, shall deny any request to issue a license under section 252.28 and chapter 245A to a nursing home or boarding care home, if that license would result in an increase in the medical assistance reimbursement amount.

In addition, the commissioner of health must not approve any construction project whose cost exceeds ~~$1,000,000~~ $1,500,000, unless:

(a) any construction costs exceeding ~~$1,000,000~~ $1,500,000 are not added to the facility's appraised value and are not included in the facility's payment rate for reimbursement under the medical assistance program; or

(b) the project:

(1) has been approved through the process described in section 144A.073;

(2) meets an exception in subdivision 3 or 4a;

(3) is necessary to correct violations of state or federal law issued by the commissioner of health;

(4) is necessary to repair or replace a portion of the facility that was damaged by fire, lightning, ground shifts, or other such hazards, including environmental hazards, provided that the provisions of subdivision 4a, clause (a), are met;

(5) as of May 1, 1992, the facility has submitted to the commissioner of health written documentation evidencing that the facility meets the "commenced construction" definition as specified in subdivision 1a, paragraph (d), or that substantial steps have been taken prior to April 1, 1992, relating to the construction project. "Substantial steps" require that the facility has made arrangements with outside parties relating to the construction project and include the hiring of an architect or construction firm, submission of preliminary plans to

the Department of Health or documentation from a financial institution that financing arrangements for the construction project have been made; or

(6) is being proposed by a licensed nursing facility that is not certified to participate in the medical assistance program and will not result in new licensed or certified beds.

Prior to the final plan approval of any construction project, the ~~commissioner~~ commissioners of health and human services shall be provided with an itemized cost estimate for the project construction costs. If a construction project is anticipated to be completed in phases, the total estimated cost of all phases of the project shall be submitted to the ~~commissioner~~ commissioners and shall be considered as one construction project. Once the construction project is completed and prior to the final clearance by the ~~commissioner~~ commissioners, the total project construction costs for the construction project shall be submitted to the ~~commissioner~~ commissioners. If the final project construction cost exceeds the dollar threshold in this subdivision, the commissioner of human services shall not recognize any of the project construction costs or the related financing costs in excess of this threshold in establishing the facility's property-related payment rate.

The dollar thresholds for construction projects are as follows: for construction projects other than those authorized in clauses (1) to (6), the dollar threshold is $1,000,000. For projects authorized after July 1, 1993, under clause (1), the dollar threshold is the cost estimate submitted with a proposal for an exception under section 144A.073, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a). For projects authorized under clauses (2) to (4), the dollar threshold is the itemized estimate project construction costs submitted to the commissioner of health at the time of final plan approval, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a).

The commissioner of health shall adopt rules to implement this section or to amend the emergency rules for granting exceptions to the moratorium on nursing homes under section 144A.073.

Sec. 6. Minnesota Statutes 2018, section 144A.071, subdivision 3, is amended to read:

Subd. 3. **Exceptions authorizing increase in beds; hardship areas.** (a) The commissioner of health, in coordination with the commissioner of human services, may approve the addition of new licensed and Medicare and Medicaid certified nursing home beds, using the criteria and process set forth in this subdivision.

(b) The commissioner, in cooperation with the commissioner of human services, shall consider the following criteria when determining that an area of the state is a hardship area with regard to access to nursing facility services:

(1) a low number of beds per thousand in a specified area using as a standard the beds per thousand people age 65 and older, in five year age groups, using data from the most recent census and population projections, weighted by each group's most recent nursing home utilization, of the county at the 20th percentile, as determined by the commissioner of human services;

(2) a high level of out-migration for nursing facility services associated with a described area from the county or counties of residence to other Minnesota counties, as determined by the commissioner of human services, using as a standard an amount greater than the out-migration of the county ranked at the 50th percentile;

(3) an adequate level of availability of noninstitutional long-term care services measured as public spending for home and community-based long-term care services per individual age 65 and older, in five year age groups, using data from the most recent census and population projections, weighted by each group's most recent nursing home utilization, as determined by the commissioner of human services using as a standard an amount greater than the 50th percentile of counties;

(4) there must be a declaration of hardship resulting from insufficient access to nursing home beds by local county agencies and area agencies on aging; and

(5) other factors that may demonstrate the need to add new nursing facility beds.

(c) On August 15 of odd-numbered years, the commissioner, in cooperation with the commissioner of human services, may publish in the State Register a request for information in which interested parties, using the data provided under section 144A.351, along with any other relevant data, demonstrate that a specified area is a hardship area with regard to access to nursing facility services. For a response to be considered, the commissioner must receive it by November 15. The commissioner shall make responses to the request for information available to the public and shall allow 30 days for comment. The commissioner shall review responses and comments and determine if any areas of the state are to be declared hardship areas.

(d) For each designated hardship area determined in paragraph (c), the commissioner shall publish a request for proposals in accordance with section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The request for proposals must be published in the State Register by March 15 following receipt of responses to the request for information.

The request for proposals must specify the number of new beds which may be added in the designated hardship area, which must not exceed the number which, if added to the existing number of beds in the area, including beds in layaway status, would have prevented it from being determined to be a hardship area under paragraph (b), clause (1). Beginning July 1, 2011, the number of new beds approved must not exceed 200 beds statewide per biennium. After June 30, 2019, the number of new beds that may be approved in a biennium must not exceed 300 statewide. For a proposal to be considered, the commissioner must receive it within six months of the publication of the request for proposals. The commissioner shall review responses to the request for proposals and shall approve or disapprove each proposal by the following July 15, in accordance with section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The commissioner shall base approvals or disapprovals on a comparison and ranking of proposals using only the criteria in subdivision 4a. Approval of a proposal expires after 18 months unless the facility has added the new beds using existing space, subject to approval by the commissioner, or has commenced construction as defined in subdivision 1a, paragraph (d). If, after the approved beds have been added, fewer than 50 percent of the beds in a facility are newly licensed, the operating payment rates previously in effect shall remain. If, after the approved beds have been added, 50 percent or more of the beds in a facility are newly licensed, operating and external fixed payment rates shall be determined according to ~~Minnesota Rules, part 9549.0057, using the limits under sections 256R.23, subdivision 5, and 256R.24, subdivision 3. External fixed costs payment rates must be determined according to section 256R.25~~ section 256R.21, subdivision 5. Property payment rates for facilities with beds added under this subdivision must be determined ~~in the same manner as rate determinations resulting from projects approved and completed under section 144A.073~~ under section 256R.26.

(e) The commissioner may:

(1) certify or license new beds in a new facility that is to be operated by the commissioner of veterans affairs or when the costs of constructing and operating the new beds are to be reimbursed by the commissioner of veterans affairs or the United States Veterans Administration; and

(2) license or certify beds in a facility that has been involuntarily delicensed or decertified for participation in the medical assistance program, provided that an application for relicensure or recertification is submitted to the commissioner by an organization that is not a related organization as defined in section 256R.02, subdivision 43, to the prior licensee within 120 days after delicensure or decertification.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 7. Minnesota Statutes 2018, section 144A.071, subdivision 4a, is amended to read:

Subd. 4a. **Exceptions for replacement beds.** It is in the best interest of the state to ensure that nursing homes and boarding care homes continue to meet the physical plant licensing and certification requirements by permitting certain construction projects. Facilities should be maintained in condition to satisfy the physical and emotional needs of residents while allowing the state to maintain control over nursing home expenditure growth.

The commissioner of health in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(a) to license or certify beds in a new facility constructed to replace a facility or to make repairs in an existing facility that was destroyed or damaged after June 30, 1987, by fire, lightning, or other hazard provided:

(i) destruction was not caused by the intentional act of or at the direction of a controlling person of the facility;

(ii) at the time the facility was destroyed or damaged the controlling persons of the facility maintained insurance coverage for the type of hazard that occurred in an amount that a reasonable person would conclude was adequate;

(iii) the net proceeds from an insurance settlement for the damages caused by the hazard are applied to the cost of the new facility or repairs;

(iv) the number of licensed and certified beds in the new facility does not exceed the number of licensed and certified beds in the destroyed facility; and

(v) the commissioner determines that the replacement beds are needed to prevent an inadequate supply of beds.

Project construction costs incurred for repairs authorized under this clause shall not be considered in the dollar threshold amount defined in subdivision 2;

(b) to license or certify beds that are moved from one location to another within a nursing home facility, provided the total costs of remodeling performed in conjunction with the relocation of beds does not exceed $1,000,000;

(c) to license or certify beds in a project recommended for approval under section 144A.073;

(d) to license or certify beds that are moved from an existing state nursing home to a different state facility, provided there is no net increase in the number of state nursing home beds;

(e) to certify and license as nursing home beds boarding care beds in a certified boarding care facility if the beds meet the standards for nursing home licensure, or in a facility that was granted an exception to the moratorium under section 144A.073, and if the cost of any remodeling of the facility does not exceed $1,000,000. If boarding care beds are licensed as nursing home beds, the number of boarding care beds in the facility must not increase beyond the number remaining at the time of the upgrade in licensure. The provisions contained in section 144A.073 regarding the upgrading of the facilities do not apply to facilities that satisfy these requirements;

(f) to license and certify up to 40 beds transferred from an existing facility owned and operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the same location as the existing facility that will serve persons with Alzheimer's disease and other related disorders. The transfer of beds may occur gradually or in stages, provided the total number of beds transferred does not exceed 40. At the time of licensure and certification of a bed or beds in the new unit, the commissioner of health shall delicense and decertify the same number of beds in the existing facility. As a condition of receiving a license or certification under this clause, the facility must make a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate as a result of the transfers allowed under this paragraph;

(g) to license and certify nursing home beds to replace currently licensed and certified boarding care beds which may be located either in a remodeled or renovated boarding care or nursing home facility or in a remodeled, renovated, newly constructed, or replacement nursing home facility within the identifiable complex of health care facilities in which the currently licensed boarding care beds are presently located, provided that the number of boarding care beds in the facility or complex are decreased by the number to be licensed as nursing home beds and further provided that, if the total costs of new construction, replacement, remodeling, or renovation exceed ten percent of the appraised value of the facility or $200,000, whichever is less, the facility makes a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate by reason of the new construction, replacement, remodeling, or renovation. The provisions contained in section 144A.073 regarding the upgrading of facilities do not apply to facilities that satisfy these requirements;

(h) to license as a nursing home and certify as a nursing facility a facility that is licensed as a boarding care facility but not certified under the medical assistance program, but only if the commissioner of human services certifies to the commissioner of health that licensing the facility as a nursing home and certifying the facility as a nursing facility will result in a net annual savings to the state general fund of $200,000 or more;

(i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home beds in a facility that was licensed and in operation prior to January 1, 1992;

(j) to license and certify new nursing home beds to replace beds in a facility acquired by the Minneapolis Community Development Agency as part of redevelopment activities in a city of the first class, provided the new facility is located within three miles of the site of the old facility. Operating and property costs for the new facility must be determined and allowed under section 256B.431 or 256B.434 or chapter 256R;

(k) to license and certify up to 20 new nursing home beds in a community-operated hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991, that suspended operation of the hospital in April 1986. The commissioner of human services shall provide the facility with the same per diem property-related payment rate for each additional licensed and certified bed as it will receive for its existing 40 beds;

(l) to license or certify beds in renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's remodeling projects do not exceed $1,000,000;

(m) to license and certify beds that are moved from one location to another for the purposes of converting up to five four-bed wards to single or double occupancy rooms in a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity of 115 beds;

(n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing facility located in Minneapolis to layaway all of its licensed and certified nursing home beds. These beds may be relicensed and recertified in a newly constructed teaching nursing home facility affiliated with a teaching hospital upon approval by the legislature. The proposal must be developed in consultation with the interagency committee on long-term care planning. The beds on layaway status shall have the same status as voluntarily delicensed and decertified beds, except that beds on layaway status remain subject to the surcharge in section 256.9657. This layaway provision expires July 1, 1998;

(o) to allow a project which will be completed in conjunction with an approved moratorium exception project for a nursing home in southern Cass County and which is

directly related to that portion of the facility that must be repaired, renovated, or replaced, to correct an emergency plumbing problem for which a state correction order has been issued and which must be corrected by August 31, 1993;

(p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to the commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed wards to single or double occupancy. Beds on layaway status shall have the same status as voluntarily delicensed and decertified beds except that beds on layaway status remain subject to the surcharge in section 256.9657, remain subject to the license application and renewal fees under section 144A.07 and shall be subject to a $100 per bed reactivation fee. In addition, at any time within three years of the effective date of the layaway, the beds on layaway status may be:

(1) relicensed and recertified upon relocation and reactivation of some or all of the beds to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or International Falls; provided that the total project construction costs related to the relocation of beds from layaway status for any facility receiving relocated beds may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073;

(2) relicensed and recertified, upon reactivation of some or all of the beds within the facility which placed the beds in layaway status, if the commissioner has determined a need for the reactivation of the beds on layaway status.

The property-related payment rate of a facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for a facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than three years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(q) to license and certify beds in a renovation and remodeling project to convert 12 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located

in Ramsey County; had a licensed capacity of 154 beds; and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(r) to license and certify up to 117 beds that are relocated from a licensed and certified 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds located in South St. Paul, provided that the nursing facility and hospital are owned by the same or a related organization and that prior to the date the relocation is completed the hospital ceases operation of its inpatient hospital services at that hospital. After relocation, the nursing facility's status shall be the same as it was prior to relocation. The nursing facility's property-related payment rate resulting from the project authorized in this paragraph shall become effective no earlier than April 1, 1996. For purposes of calculating the incremental change in the facility's rental per diem resulting from this project, the allowable appraised value of the nursing facility portion of the existing health care facility physical plant prior to the renovation and relocation may not exceed $2,490,000;

(s) to license and certify two beds in a facility to replace beds that were voluntarily delicensed and decertified on June 28, 1991;

(t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed nursing home and 21-bed boarding care home facility in Minneapolis, notwithstanding the licensure and certification after July 1, 1995, of the Minneapolis facility as a 147-bed nursing home facility after completion of a construction project approved in 1993 under section 144A.073, to be laid away upon 30 days' prior written notice to the commissioner. Beds on layaway status shall have the same status as voluntarily delicensed or decertified beds except that they shall remain subject to the surcharge in section 256.9657. The 16 beds on layaway status may be relicensed as nursing home beds and recertified at any time within five years of the effective date of the layaway upon relocation of some or all of the beds to a licensed and certified facility located in Watertown, provided that the total project construction costs related to the relocation of beds from layaway status for the Watertown facility may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073.

The property-related payment rate of the facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for the facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per

diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than five years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(u) to license and certify beds that are moved within an existing area of a facility or to a newly constructed addition which is built for the purpose of eliminating three- and four-bed rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed capacity of 129 beds;

(v) to relocate 36 beds in Crow Wing County and four beds from Hennepin County to a 160-bed facility in Crow Wing County, provided all the affected beds are under common ownership;

(w) to license and certify a total replacement project of up to 49 beds located in Norman County that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of ~~Minnesota Rules, part 9549.0057,~~ section 256R.27 and the reimbursement provisions of chapter 256R. Property-related reimbursement rates shall be determined under section 256R.26, taking into account any federal or state flood-related loans or grants provided to the facility;

(x) to license and certify to the licensee of a nursing home in Polk County that was destroyed by flood in 1997 replacement projects with a total of up to 129 beds, with at least 25 beds to be located in Polk County and up to 104 beds distributed among up to three other counties. These beds may only be distributed to counties with fewer than the median number of age intensity adjusted beds per thousand, as most recently published by the commissioner of human services. If the licensee chooses to distribute beds outside of Polk County under this paragraph, prior to distributing the beds, the commissioner of health must approve the location in which the licensee plans to distribute the beds. The commissioner of health shall consult with the commissioner of human services prior to approving the location of the proposed beds. The licensee may combine these beds with beds relocated from other nursing facilities as provided in section 144A.073, subdivision 3c. The operating payment rates for the new nursing facilities shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, parts 9549.0010 to 9549.0080. Property-related reimbursement rates shall be determined under section 256R.26. If the replacement beds

permitted under this paragraph are combined with beds from other nursing facilities, the rates shall be calculated as the weighted average of rates determined as provided in this paragraph and section 256R.50;

(y) to license and certify beds in a renovation and remodeling project to convert 13 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey County, was not owned by a hospital corporation, had a licensed capacity of 64 beds, and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(z) to license and certify up to 150 nursing home beds to replace an existing 285 bed nursing facility located in St. Paul. The replacement project shall include both the renovation of existing buildings and the construction of new facilities at the existing site. The reduction in the licensed capacity of the existing facility shall occur during the construction project as beds are taken out of service due to the construction process. Prior to the start of the construction process, the facility shall provide written information to the commissioner of health describing the process for bed reduction, plans for the relocation of residents, and the estimated construction schedule. The relocation of residents shall be in accordance with the provisions of law and rule;

(aa) to allow the commissioner of human services to license an additional 36 beds to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that the total number of licensed and certified beds at the facility does not increase;

(bb) to license and certify a new facility in St. Louis County with 44 beds constructed to replace an existing facility in St. Louis County with 31 beds, which has resident rooms on two separate floors and an antiquated elevator that creates safety concerns for residents and prevents nonambulatory residents from residing on the second floor. The project shall include the elimination of three- and four-bed rooms;

(cc) to license and certify four beds in a 16-bed certified boarding care home in Minneapolis to replace beds that were voluntarily delicensed and decertified on or before March 31, 1992. The licensure and certification is conditional upon the facility periodically assessing and adjusting its resident mix and other factors which may contribute to a potential institution for mental disease declaration. The commissioner of human services shall retain

the authority to audit the facility at any time and shall require the facility to comply with any requirements necessary to prevent an institution for mental disease declaration, including delicensure and decertification of beds, if necessary;

(dd) to license and certify 72 beds in an existing facility in Mille Lacs County with 80 beds as part of a renovation project. The renovation must include construction of an addition to accommodate ten residents with beginning and midstage dementia in a self-contained living unit; creation of three resident households where dining, activities, and support spaces are located near resident living quarters; designation of four beds for rehabilitation in a self-contained area; designation of 30 private rooms; and other improvements;

(ee) to license and certify beds in a facility that has undergone replacement or remodeling as part of a planned closure under section 256R.40;

(ff) to license and certify a total replacement project of up to 124 beds located in Wilkin County that are in need of relocation from a nursing home significantly damaged by flood. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of ~~Minnesota Rules, part 9549.0057,~~ section 256R.27 and the reimbursement provisions of chapter 256R. Property-related reimbursement rates shall be determined under section 256R.26, taking into account any federal or state flood-related loans or grants provided to the facility;

(gg) to allow the commissioner of human services to license an additional nine beds to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 240-bed nursing home located in Duluth, provided that the total number of licensed and certified beds at the facility does not increase;

(hh) to license and certify up to 120 new nursing facility beds to replace beds in a facility in Anoka County, which was licensed for 98 beds as of July 1, 2000, provided the new facility is located within four miles of the existing facility and is in Anoka County. Operating and property rates shall be determined and allowed under chapter 256R and Minnesota Rules, parts 9549.0010 to 9549.0080; or

(ii) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka County that, as of March 25, 2001, is in the active process of closing, to a 122-licensed bed nonprofit nursing facility located in the city of Columbia Heights or its affiliate. The transfer is effective when the receiving facility notifies the commissioner in writing of the number of beds accepted. The commissioner shall place all transferred beds on layaway status held in the name of the receiving facility. The layaway adjustment provisions of section 256B.431, subdivision 30, do not apply to this layaway. The receiving facility may only remove the

beds from layaway for recertification and relicensure at the receiving facility's current site, or at a newly constructed facility located in Anoka County. The receiving facility must receive statutory authorization before removing these beds from layaway status, or may remove these beds from layaway status if removal from layaway status is part of a moratorium exception project approved by the commissioner under section 144A.073.

Sec. 8. Minnesota Statutes 2018, section 144A.071, subdivision 4c, is amended to read:

Subd. 4c. **Exceptions for replacement beds after June 30, 2003.** (a) The commissioner of health, in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(1) to license and certify an 80-bed city-owned facility in Nicollet County to be constructed on the site of a new city-owned hospital to replace an existing 85-bed facility attached to a hospital that is also being replaced. The threshold allowed for this project under section 144A.073 shall be the maximum amount available to pay the additional medical assistance costs of the new facility;

(2) to license and certify 29 beds to be added to an existing 69-bed facility in St. Louis County, provided that the 29 beds must be transferred from active or layaway status at an existing facility in St. Louis County that had 235 beds on April 1, 2003.

The licensed capacity at the 235-bed facility must be reduced to 206 beds, but the payment rate at that facility shall not be adjusted as a result of this transfer. The operating payment rate of the facility adding beds after completion of this project shall be the same as it was on the day prior to the day the beds are licensed and certified. This project shall not proceed unless it is approved and financed under the provisions of section 144A.073;

(3) to license and certify a new 60-bed facility in Austin, provided that: (i) 45 of the new beds are transferred from a 45-bed facility in Austin under common ownership that is closed and 15 of the new beds are transferred from a 182-bed facility in Albert Lea under common ownership; (ii) the commissioner of human services is authorized by the 2004 legislature to negotiate budget-neutral planned nursing facility closures; and (iii) money is available from planned closures of facilities under common ownership to make implementation of this clause budget-neutral to the state. The bed capacity of the Albert Lea facility shall be reduced to 167 beds following the transfer. Of the 60 beds at the new facility, 20 beds shall be used for a special care unit for persons with Alzheimer's disease or related dementias;

(4) to license and certify up to 80 beds transferred from an existing state-owned nursing facility in Cass County to a new facility located on the grounds of the Ah-Gwah-Ching campus. The operating cost payment rates for the new facility shall be determined based on the interim and settle-up payment provisions of ~~Minnesota Rules, part 9549.0057,~~ section 256R.27 and the reimbursement provisions of chapter 256R. The property payment rate for the first three years of operation shall be $35 per day. For subsequent years, the property payment rate of $35 per day shall be adjusted for inflation as provided in section 256B.434, subdivision 4, paragraph (c), as long as the facility has a contract under section 256B.434;

(5) to initiate a pilot program to license and certify up to 80 beds transferred from an existing county-owned nursing facility in Steele County relocated to the site of a new acute care facility as part of the county's Communities for a Lifetime comprehensive plan to create innovative responses to the aging of its population. Upon relocation to the new site, the nursing facility shall delicense 28 beds. The payment rate for external fixed costs for the new facility shall be increased by an amount as calculated according to items (i) to (v):

(i) compute the estimated decrease in medical assistance residents served by the nursing facility by multiplying the decrease in licensed beds by the historical percentage of medical assistance resident days;

(ii) compute the annual savings to the medical assistance program from the delicensure of 28 beds by multiplying the anticipated decrease in medical assistance residents, determined in item (i), by the existing facility's weighted average payment rate multiplied by 365;

(iii) compute the anticipated annual costs for community-based services by multiplying the anticipated decrease in medical assistance residents served by the nursing facility, determined in item (i), by the average monthly elderly waiver service costs for individuals in Steele County multiplied by 12;

(iv) subtract the amount in item (iii) from the amount in item (ii);

(v) divide the amount in item (iv) by an amount equal to the relocated nursing facility's occupancy factor under section 256B.431, subdivision 3f, paragraph (c), multiplied by the historical percentage of medical assistance resident days; and

(6) to consolidate and relocate nursing facility beds to a new site in Goodhue County and to integrate these services with other community-based programs and services under a communities for a lifetime pilot program and comprehensive plan to create innovative responses to the aging of its population. Two nursing facilities, one for 84 beds and one for 65 beds, in the city of Red Wing licensed on July 1, 2015, shall be consolidated into a newly renovated 64-bed nursing facility resulting in the delicensure of 85 beds. Notwithstanding

the carryforward of the approval authority in section 144A.073, subdivision 11, the funding approved in April 2009 by the commissioner of health for a project in Goodhue County shall not carry forward. The closure of the 85 beds shall not be eligible for a planned closure rate adjustment under section 256R.40. The construction project permitted in this clause shall not be eligible for a threshold project rate adjustment under section 256B.434, subdivision 4f. The payment rate for external fixed costs for the new facility shall be increased by an amount as calculated according to items (i) to (vi):

(i) compute the estimated decrease in medical assistance residents served by both nursing facilities by multiplying the difference between the occupied beds of the two nursing facilities for the reporting year ending September 30, 2009, and the projected occupancy of the facility at 95 percent occupancy by the historical percentage of medical assistance resident days;

(ii) compute the annual savings to the medical assistance program from the delicensure by multiplying the anticipated decrease in the medical assistance residents, determined in item (i), by the hospital-owned nursing facility weighted average payment rate multiplied by 365;

(iii) compute the anticipated annual costs for community-based services by multiplying the anticipated decrease in medical assistance residents served by the facilities, determined in item (i), by the average monthly elderly waiver service costs for individuals in Goodhue County multiplied by 12;

(iv) subtract the amount in item (iii) from the amount in item (ii);

(v) multiply the amount in item (iv) by 57.2 percent; and

(vi) divide the difference of the amount in item (iv) and the amount in item (v) by an amount equal to the relocated nursing facility's occupancy factor under section 256B.431, subdivision 3f, paragraph (c), multiplied by the historical percentage of medical assistance resident days.

(b) Projects approved under this subdivision shall be treated in a manner equivalent to projects approved under subdivision 4a.

Sec. 9. Minnesota Statutes 2018, section 144A.071, subdivision 5a, is amended to read:

Subd. 5a. **Cost estimate of a moratorium exception project.** ~~(a)~~ For the purposes of this section and section 144A.073, the cost estimate of a moratorium exception project shall include the effects of the proposed project on the costs of the state subsidy for community-based services, nursing services, and housing in institutional and noninstitutional settings. The commissioner of health, in cooperation with the commissioner of human

services, shall define the method for estimating these costs in the permanent rule implementing section 144A.073. The commissioner of human services shall prepare an estimate of the property-related payment rate to be established upon completion of the project and total state annual long-term costs of each moratorium exception proposal. The property-related payment rate estimate shall be made using the actual cost of the project but the final property rate must be based on the appraisal and subject to the limitations in section 256R.26, subdivision 6.

~~(b) The interest rate to be used for estimating the cost of each moratorium exception project proposal shall be the lesser of either the prime rate plus two percentage points, or the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation plus two percentage points as published in the Wall Street Journal and in effect 56 days prior to the application deadline. If the applicant's proposal uses this interest rate, the commissioner of human services, in determining the facility's actual property-related payment rate to be established upon completion of the project must use the actual interest rate obtained by the facility for the project's permanent financing up to the maximum permitted under Minnesota Rules, part 9549.0060, subpart 6.~~

~~The applicant may choose an alternate interest rate for estimating the project's cost. If the applicant makes this election, the commissioner of human services, in determining the facility's actual property-related payment rate to be established upon completion of the project, must use the lesser of the actual interest rate obtained for the project's permanent financing or the interest rate which was used to estimate the proposal's project cost. For succeeding rate years, the applicant is at risk for financing costs in excess of the interest rate selected.~~

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 10. Minnesota Statutes 2018, section 144A.073, subdivision 3c, is amended to read:

Subd. 3c. ~~**Cost neutral**~~ **Relocation projects.** ~~(a)~~ Notwithstanding subdivision 3, the commissioner may at any time accept proposals, or amendments to proposals previously approved under this section, for relocations ~~that are cost neutral with respect to state costs as defined in section 144A.071, subdivision 5a~~. The commissioner, in consultation with the commissioner of human services, shall evaluate proposals according to subdivision 4a, clauses (1), (4), (5), (6), and (8), and other criteria established in rule or law. ~~The commissioner of human services shall determine the allowable payment rates of the facility receiving the beds in accordance with section 256R.50.~~ The commissioner shall approve or disapprove a project within 90 days.

~~(b) For the purposes of paragraph (a), cost neutrality shall be measured over the first three 12-month periods of operation after completion of the project.~~

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 11. Minnesota Statutes 2018, section 256B.434, subdivision 1, is amended to read:

Subdivision 1. ~~**Alternative payment demonstration project established**~~ **Contractual agreements.** ~~The commissioner of human services shall establish a contractual alternative payment demonstration project for paying for nursing facility services under the medical assistance program. A nursing facility may apply to be paid under the contractual alternative payment demonstration project instead of the cost-based payment system established under section 256B.431. A nursing facility~~ Nursing facilities located in Minnesota electing to ~~use the alternative payment demonstration project~~ enroll as a medical assistance provider must enter into a contract with the commissioner. Payment rates and procedures ~~for facilities electing to use the alternative payment demonstration project~~ are determined and governed by this section and by the terms of the contract. The commissioner may negotiate different contract terms for different nursing facilities.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 12. Minnesota Statutes 2018, section 256B.434, subdivision 3, is amended to read:

Subd. 3. **Duration and termination of contracts.** ~~(a) Subject to available resources, the commissioner may begin to execute contracts with nursing facilities November 1, 1995.~~

~~(b)~~ (a) All contracts entered into under this section are for a term not to exceed four years. Either party may terminate a contract at any time without cause by providing 90 calendar days advance written notice to the other party. The decision to terminate a contract is not appealable. ~~Notwithstanding section 16C.05, subdivision 2, paragraph (a), clause (5), the contract shall be renegotiated for additional terms of up to four years, unless either party provides written notice of termination.~~ The provisions of the contract shall be renegotiated at a minimum of every four years by the parties prior to the expiration date of the contract. The parties may voluntarily ~~renegotiate~~ amend the terms of the contract at any time by mutual agreement.

~~(c)~~ (b) If a nursing facility fails to comply with the terms of a contract, the commissioner shall provide reasonable notice regarding the breach of contract and a reasonable opportunity for the facility to come into compliance. If the facility fails to come into compliance or to remain in compliance, the commissioner may terminate the contract. ~~If a contract is~~

~~terminated, the contract payment remains in effect for the remainder of the rate year in which the contract was terminated, but in all other respects the provisions of this section do not apply to that facility effective the date the contract is terminated. The contract shall contain a provision governing the transition back to the cost-based reimbursement system established under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080. A contract entered into under this section may be amended by mutual agreement of the parties.~~

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 13. **[256M.42] ADULT PROTECTION GRANT ALLOCATIONS.**

Subdivision 1. **Formula.** (a) The commissioner shall allocate state money appropriated under this section to each county board and tribal government approved by the commissioner to assume county agency duties for adult protective services or as a lead investigative agency under section 626.557 on an annual basis in an amount determined according to the following formula:

(1) 25 percent must be allocated on the basis of the number of reports of suspected vulnerable adult maltreatment under sections 626.557 and 626.5572, when the county or tribe is responsible as determined by the most recent data of the commissioner; and

(2) 75 percent must be allocated on the basis of the number of screened-in reports for adult protective services or vulnerable adult maltreatment investigations under sections 626.557 and 626.5572, when the county or tribe is responsible as determined by the most recent data of the commissioner.

(b) The commissioner is precluded from changing the formula under this subdivision or recommending a change to the legislature without public review and input.

Subd. 2. **Payment.** The commissioner shall make allocations for the state fiscal year starting July 1, 2019, and to each county board or tribal government on or before October 10, 2019. The commissioner shall make allocations under subdivision 1 to each county board or tribal government each year thereafter on or before July 10.

Subd. 3. **Prohibition on supplanting existing money.** Money received under this section must be used for staffing for protection of vulnerable adults or to expand adult protective services. Money must not be used to supplant current county or tribe expenditures for these purposes.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 14. Minnesota Statutes 2018, section 256R.02, subdivision 8, is amended to read:

Subd. 8. **Capital assets.** "Capital assets" means a nursing facility's buildings, ~~attached fixtures~~ fixed equipment, land improvements, leasehold improvements, and all additions to or replacements of those assets used directly for resident care.

Sec. 15. Minnesota Statutes 2018, section 256R.02, subdivision 19, is amended to read:

Subd. 19. **External fixed costs.** "External fixed costs" means costs related to the nursing home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122; family advisory council fee under section 144A.33; scholarships under section 256R.37; ~~planned closure rate adjustments under section 256R.40; consolidation rate adjustments under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d; single-bed room incentives under section 256R.41;~~ property taxes, special assessments, and payments in lieu of taxes; employer health insurance costs; quality improvement incentive payment rate adjustments under section 256R.39; performance-based incentive payments under section 256R.38; special dietary needs under section 256R.51; rate adjustments for compensation-related costs for minimum wage changes under section 256R.49 provided on or after January 1, 2018; and Public Employees Retirement Association employer costs.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 16. Minnesota Statutes 2018, section 256R.02, is amended by adding a subdivision to read:

Subd. 25a. **Interim payment rates.** "Interim payment rates" means the total operating and external fixed costs payment rates determined by anticipated costs and resident days reported on an interim cost report as described in section 256R.27.

Sec. 17. Minnesota Statutes 2018, section 256R.02, is amended by adding a subdivision to read:

Subd. 47a. **Settle up payment rates.** "Settle up payment rates" means the total operating and external fixed costs payment rates determined by actual allowable costs and resident days reported on a settle up cost report as described under section 256R.27.

Sec. 18. Minnesota Statutes 2018, section 256R.08, subdivision 1, is amended to read:

Subdivision 1. **Reporting of financial statements.** (a) No later than February 1 of each year, a nursing facility shall:

(1) provide the state agency with a copy of its audited financial statements or its working trial balance;

(2) provide the state agency with a statement of ownership for the facility;

(3) provide the state agency with separate, audited financial statements or working trial balances for every other facility owned in whole or in part by an individual or entity that has an ownership interest in the facility;

(4) provide the state agency with information regarding whether the licensee, or a general partner, director, or officer of the licensee, has an ownership or control interest of five percent or more in a related party or related organization that provides any service to the skilled nursing facility. If the licensee, or the general partner, director, or officer of the licensee has such an interest, the licensee shall disclose all services provided to the skilled nursing facility, the number of individuals who provide that service at the skilled nursing facility, and any other information requested by the state agency. If goods, fees, and services collectively worth $10,000 or more per year are delivered to the skilled nursing facility, the disclosure required pursuant to this subdivision shall include the related party and related organization profit and loss statement, and the Payroll-Based Journal public use data;

~~(4)~~ (5) upon request, provide the state agency with separate, audited financial statements or working trial balances for every organization with which the facility conducts business and which is owned in whole or in part by an individual or entity which has an ownership interest in the facility;

~~(5)~~ (6) provide the state agency with copies of leases, purchase agreements, and other documents related to the lease or purchase of the nursing facility; and

~~(6)~~ (7) upon request, provide the state agency with copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services which are claimed as allowable costs.

(b) Audited financial statements submitted under paragraph (a) must include a balance sheet, income statement, statement of the rate or rates charged to private paying residents, statement of retained earnings, statement of cash flows, notes to the financial statements, audited applicable supplemental information, and the public accountant's report. Public accountants must conduct audits in accordance with chapter 326A. The cost of an audit shall not be an allowable cost unless the nursing facility submits its audited financial statements in the manner otherwise specified in this subdivision. A nursing facility must permit access by the state agency to the public accountant's audit work papers that support the audited financial statements submitted under paragraph (a).

(c) Documents or information provided to the state agency pursuant to this subdivision shall be public.

(d) If the requirements of paragraphs (a) and (b) are not met, the reimbursement rate may be reduced to 80 percent of the rate in effect on the first day of the fourth calendar month after the close of the reporting period and the reduction shall continue until the requirements are met.

(e) Licensees shall provide the information required in this section to the commissioner in a manner prescribed by the commissioner.

(f) For purposes of this section, the following terms have the meanings given:

(1) "profit and loss statement" means the most recent annual statement on profits and losses finalized by a related party for the most recent year available; and

(2) "related party" means an organization related to the licensee provider or that is under common ownership or control, as defined in Code of Federal Regulations, title 42, section 413.17(b).

**EFFECTIVE DATE.** This section is effective November 1, 2019.

Sec. 19. Minnesota Statutes 2018, section 256R.10, is amended by adding a subdivision to read:

Subd. 8. **Pilot projects for energy-related programs.** (a) The commissioner shall develop a pilot project to reduce overall energy consumption and evaluate the financial impacts associated with property assessed clean energy (PACE) approved projects in nursing facilities.

(b) Notwithstanding section 256R.02, subdivision 48a, the commissioner may make payments to facilities for the allowable costs of special assessments for approved energy-related program payments authorized under sections 216C.435 and 216C.436. The commissioner shall limit the amount of any payment and the number of contract amendments under this subdivision to operate the energy-related program within funds appropriated for this purpose.

(c) The commissioner shall approve proposals through a contract which shall specify the level of payment, provided that each facility demonstrates:

(1) completion of a facility-specific energy assessment or energy audit and recommended energy conservation measures that, in aggregate, meet the cost-effectiveness requirements of section 216B.241;

(2) a completed PACE application and recommended approval by a PACE program administrator authorized under sections 216C.435 and 216C.436; and

(3) the facility's reported spending on utilities per resident day since calendar year 2016 is higher than average for similar facilities.

(d) Payments to facilities under this subdivision shall be in the form of time-limited rate adjustments which shall be included in the external fixed costs payment rate under section 256R.25. The commissioner shall select from facilities which meet the requirements of paragraph (c) using a competitive application process.

(e) Allowable costs for special assessments for approved energy-related program payments cannot exceed the amount of debt service for net expenditures for the project and must meet the cost-effective energy improvements requirements described in section 216C.435, subdivision 3a. Any credits or rebates related to the project must be offset. A project cost is not an allowable cost on the cost report as a special assessment if it has been or will be used to increase the facility's property rate.

(f) The external fixed costs payment rate for the PACE allowable costs shall be reduced by an amount equal to the utility per diem included in the other operating payment rate under section 256R.24, that is associated with the energy project.

Sec. 20. Minnesota Statutes 2018, section 256R.16, subdivision 1, is amended to read:

Subdivision 1. **Calculation of a quality score.** (a) The commissioner shall determine a quality score for each nursing facility using quality measures established in section 256B.439, according to methods determined by the commissioner in consultation with stakeholders and experts, and using the most recently available data as provided in the Minnesota Nursing Home Report Card. These methods shall be exempt from the rulemaking requirements under chapter 14.

(b) For each quality measure, a score shall be determined with the number of points assigned as determined by the commissioner using the methodology established according to this subdivision. The determination of the quality measures to be used and the methods of calculating scores may be revised annually by the commissioner.

(c) The quality score shall include up to 50 points related to the Minnesota quality indicators score derived from the minimum data set, up to 40 points related to the resident quality of life score derived from the consumer survey conducted under section 256B.439, subdivision 3, and up to ten points related to the state inspection results score.

(d) The commissioner, in cooperation with the commissioner of health, may adjust the formula in paragraph (c), or the methodology for computing the total quality score, ~~effective July 1 of any year,~~ with five months advance public notice. In changing the formula, the commissioner shall consider quality measure priorities registered by report card users, advice of stakeholders, and available research.

Sec. 21. Minnesota Statutes 2018, section 256R.21, is amended by adding a subdivision to read:

Subd. 5. **Total payment rate for new facilities.** For a new nursing facility created under section 144A.073, subdivision 3c, the total payment rate must be determined according to this section, except:

(1) the direct care payment rate used in subdivision 2, clause (1), must be determined according to section 256R.27;

(2) the other care-related payment rate used in subdivision 2, clause (2), must be determined according to section 256R.27;

(3) the external fixed costs payment rate used in subdivision 4, clause (2), must be determined according to section 256R.27; and

(4) the property payment rate used in subdivision 4, clause (3), must be determined according to section 256R.26.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 22. Minnesota Statutes 2018, section 256R.23, subdivision 5, is amended to read:

Subd. 5. **Determination of total care-related payment rate limits.** The commissioner must determine each facility's total care-related payment rate limit by:

(1) multiplying the facility's quality score, as determined under section 256R.16, subdivision 1, paragraph (d), by ~~0.5625~~ 2.0;

(2) ~~adding 89.375 to~~ subtracting 40.0 from the amount determined in clause (1), and dividing the total by 100; ~~and~~

(3) multiplying the amount determined in clause (2) by the median total care-related cost per day~~.~~; and

(4) multiplying the amount determined in clause (3) by the most-recent available Core-Based Statistical Area wage indices established by the Centers for Medicare and Medicaid Services for the Skilled Nursing Facility Prospective Payment System.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 23. Minnesota Statutes 2018, section 256R.24, is amended to read:

**256R.24 OTHER OPERATING PAYMENT RATE.**

Subdivision 1. **Determination of ~~other operating~~ laundry, housekeeping, and dietary cost per day.** Each facility's ~~other operating~~ laundry, housekeeping, and dietary cost per day is ~~its other operating~~ equal to its laundry, housekeeping, and dietary costs divided by the sum of the facility's resident days.

Subd. 2. **Determination of the ~~median other operating cost per day~~ medians.** The commissioner must determine the laundry, housekeeping, and dietary median ~~other operating~~ cost per resident day using the cost reports from nursing facilities in Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties.

Subd. 3. **Determination of ~~the other operating~~ payment rate for laundry, housekeeping, and dietary.** A facility's ~~other operating~~ payment rate for laundry, housekeeping, and dietary equals 105 percent of the median ~~other operating cost per day~~ for laundry, housekeeping, and dietary cost as determined in subdivision 2.

Subd. 4. **Administrative, maintenance, and plant operations.** (a) The payment rate for administrative, maintenance, and plant operations is $48.57 per day effective January 1, 2020. For the rate period January 1, 2021, through December 31, 2023, this payment rate is increased by one percent annually on January 1.

(b) For rate years beginning on and after January 1, 2024, this payment rate is adjusted by a forecasting market basket and forecasting index. The adjustment factor must come from the Information Handling Services Healthcare Cost Review, the Skilled Nursing Facility Total Market Basket Index, and the four-quarter moving average percentage change line or a comparable index if this index ceases to be published. The commissioner shall use the fourth quarter index of the upcoming calendar year from the forecast published for the third quarter of the calendar year immediately prior to the rate year for which the rate is being determined.

Subd. 5. **Determination of the other operating payment rate.** A facility's other operating payment rate equals the sum of the factors determined in subdivisions 3 and 4.

Sec. 24. Minnesota Statutes 2018, section 256R.25, is amended to read:

**256R.25 EXTERNAL FIXED COSTS PAYMENT RATE.**

(a) The payment rate for external fixed costs is the sum of the amounts in paragraphs (b) to ~~(n)~~ (k).

(b) For a facility licensed as a nursing home, the portion related to the provider surcharge under section 256.9657 is equal to $8.86 per resident day. For a facility licensed as both a nursing home and a boarding care home, the portion related to the provider surcharge under section 256.9657 is equal to $8.86 per resident day multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(c) The portion related to the licensure fee under section 144.122, paragraph (d), is the amount of the fee divided by the sum of the facility's resident days.

(d) The portion related to development and education of resident and family advisory councils under section 144A.33 is $5 per resident day divided by 365.

(e) The portion related to scholarships is determined under section 256R.37.

~~(f) The portion related to planned closure rate adjustments is as determined under section 256R.40, subdivision 5, and Minnesota Statutes 2010, section 256B.436.~~

~~(g) The portion related to consolidation rate adjustments shall be as determined under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d.~~

~~(h) The portion related to single-bed room incentives is as determined under section 256R.41.~~

~~(i)~~ (f) The portions related to real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility are the ~~actual~~ allowable amounts divided by the sum of the facility's resident days. Allowable costs under this paragraph for payments made by a nonprofit nursing facility that are in lieu of real estate taxes shall not exceed the amount which the nursing facility would have paid to a city or township and county for fire, police, sanitation services, and road maintenance costs had real estate taxes been levied on that property for those purposes.

~~(j)~~ (g) The portion related to employer health insurance costs is the allowable costs divided by the sum of the facility's resident days.

~~(k)~~ (h) The portion related to the Public Employees Retirement Association is ~~actual~~ allowable costs divided by the sum of the facility's resident days.

~~(l)~~ (i) The portion related to quality improvement incentive payment rate adjustments is the amount determined under section 256R.39.

~~(m)~~ (j) The portion related to performance-based incentive payments is the amount determined under section 256R.38.

~~(n)~~ (k) The portion related to special dietary needs is the amount determined under section 256R.51.

**EFFECTIVE DATE.** This section is effective January, 1, 2020.

Sec. 25. Minnesota Statutes 2018, section 256R.26, is amended to read:

**256R.26 PROPERTY PAYMENT RATE.**

Subdivision 1. **Generally.** ~~The property payment rate for a nursing facility is the property rate established for the facility under sections 256B.431 and 256B.434.~~ (a) For rate years beginning on or after January 1, 2020, the commissioner shall reimburse nursing facilities participating in the medical assistance program for the rental use of real estate and depreciable assets according to this section and sections 256R.261 to 256R.27. The property payment rate made under this methodology is the only payment for costs related to capital assets, including depreciation expense, interest and lease expenses for all depreciable assets, also including depreciable movable equipment, land improvements, and land.

(b) The commercial valuation system selected by the commissioner must be utilized in all appraisals. The appraisal is not intended to exactly reflect market value, and no adjustments or substitutions are permitted for any alternative analysis of properties than the selected commercial valuation system.

(c) Based on the valuation of a building and fixed equipment, the property appraisal firm selected by the commissioner must produce a report detailing both the depreciated replacement cost (DRC) and undepreciated replacement cost (URC) of the nursing facility. The valuation excludes depreciable movable equipment, land, or land improvements. The valuation must be adjusted for any shared area included in the DRC and URC not used for nursing facility purposes. Physical plant for central office operations is not included in the appraisal.

(d) The appraisal initially may include the full value of all shared areas. The DRC, URC, and square footage are established by an appraisal and must be adjusted to reflect only the nursing facility usage of shared areas in the final nursing facility values. The adjustment must be based on a Medicare-approved allocation basis for the type of service provided by

each area. Shared areas outside the appraised space must be added to the DRC, URC, and related square footage using the average of each value from the space in the appraisal.

Subd. 2. **Appraised value.** For rate years beginning on or after January 1, 2020, the DRC and URC are based on the appraisals of a building and attached fixtures as determined by the contracted property appraisal firm using a commercial valuation system selected by the commissioner.

Subd. 3. **Initial rate year.** The property payment rate calculated under section 256R.265 for the initial rate year effective January 1, 2020, must be a per diem amount based on the DRC and URC of a nursing facility's building and attached fixtures, as estimated by a commercial property appraisal firm in 2016. The initial values for both the DRC and URC, adjusted for nonnursing facility space, must be increased by six percent.

Subd. 4. **Subsequent rate years.** (a) Beginning in calendar year 2020, the commissioner shall contract with a property appraisal firm to appraise the building and attached fixtures for nursing facilities using the commercial valuation system. Approximately one-third of the nursing facilities must be appraised each year.

(b) If a nursing facility wishes to appeal findings of fact in the appraisal report, the nursing facility must request a revision within 20 calendar days after receipt of the appraisal report.

(c) The property payment rate for rate year beginning January 1, 2021, for the one-third of nursing facilities that are newly appraised in 2020 must be based upon new DRCs and URCs for buildings and attached fixtures as determined by the contracted property appraisal firm.

(d) The property payment rate for rate years beginning January 1, 2021, and January 1, 2022, for the remainder of the nursing facilities that were not previously appraised, must use the net DRC and URC used in the January 1, 2020, property payment rates adjusted for inflation before any formula limitations are applied. The index for the inflation adjustment must be based on the change in the United States All-Items Consumer Price Index (CPI-U) forecasted by the Reports and Forecasts Division of the Department of Human Services in the third quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. Nursing facilities under this paragraph must have the property payment rates beginning January 1, 2022, and January 1, 2023, based on new replacement costs and depreciated values as determined in appraisals based on the three-year cycle.

(e) For the nursing facilities that have an on-site property appraisal conducted by the commissioner's designee after the initial 2016 appraisal, the most recent appraisal must be used in subsequent years until a new on-site property appraisal is conducted. In the years after the initial appraisal, the most recent DRC and URC must be updated through the commercial valuation system. These valuations are updates only and not subject to revisions of any of the original valuations or appeal by the nursing facility.

Subd. 5. **Special reappraisals.** (a) A nursing facility that completes an addition to or replacement of a building or attached fixtures as approved in section 144A.073 after January 1, 2020, may request a property rate adjustment effective the first of January, April, July, or October after project completion. The nursing facility must submit all cost data related to the project to the commissioner within 90 days of project completion. The commissioner must add the nursing facility to the next group of scheduled appraisals. The nursing facility's updated appraisal must be used to calculate a revised property rate effective the first of January, April, July, or October after project completion. If an updated appraisal cannot be scheduled within 90 days of the effective date of the revised property, the commissioner must establish an interim valuation which must be adjusted retroactively when the updated appraisal is available. For a nursing facility with projects approved under section 144A.073 prior to January 1, 2020, moratorium project construction adjustments must be calculated under Minnesota Statutes 2018, section 256B.434, subdivision 4f, and the adjustment added to the nursing facility's hold harmless rate effective the first of January, April, July, or October after project completion. This adjustment is in addition to the updated appraisal described in this paragraph.

(b) A nursing facility that completes a threshold construction project after January 1, 2020, may submit a project rate adjustment request to the commissioner if the building improvement or addition costs exceed $300,000 and the threshold construction project is not reflected in an appraisal used for rate setting. The cost must be incurred by the nursing facility, or if the nursing facility is leased and the cost is incurred by the lease holder, the provider's lease has been increased for the project. Threshold project costs exceeding a total of $1,500,000 within a three-year period, or a prorated amount if the appraisals are less than three years apart, must not be recognized. The property payment rate must be updated to reflect the new DRC and URC values effective the first of January or July after project completion. In subsequent property payment rate calculations, an addition to the DRC and URC must be eliminated once a full appraisal is complete for the nursing facility after project completion. At the option of the commissioner, the appraisal schedule may be adjusted for

nursing facilities completing threshold projects. Threshold project costs are not considered if the costs were incurred prior to the date of the last appraisal.

(c) Effective January 1, 2020, a nursing facility new to the medical assistance program must have the building and fixed equipment appraised by the property appraisal firm upon completion of construction of the nursing facility, or, if not newly constructed, upon entering the medical assistance program. If an appraisal cannot be scheduled within 90 days of the certification date, the commissioner must establish an interim valuation to be adjusted retroactively when the appraisal is available.

Subd. 6. **Limitation on appraisal valuations.** Effective for appraisals conducted on or after January 1, 2020, the increase in the URC is limited to $500,000 per year since the last completed appraisal plus any completed project costs approved under section 144A.073. Any limitation to the URC must be applied in the same proportion to the DRC.

Subd. 7. **Total hold harmless rate.** (a) Total hold harmless rate includes planned closure adjustments under Minnesota Statutes 2018, section 256R.40, subdivision 5; consolidation adjustments under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d; equity incentives under sections 256B.431, subdivision 16, and Minnesota Statutes 2018, 256B.434, subdivision 4f; single-bed incentives under Minnesota Statutes 2018, section 256R.41; project construction costs under Minnesota Statutes 2018, section 144A.071, subdivision 1a, paragraph (j); and all components of the property payment rate under section 256R.26 in effect on December 31, 2019.

(b) For moratorium projects as defined under sections 144A.071 and 144A.073 that are eligible for rate adjustments approved prior to January 1, 2020, but not reflected in the rate on December 31, 2019, the moratorium rate adjustments determined under Minnesota Statutes 2018, sections 256B.431, subdivisions 3f, 17, 17a, 17c, 17d, 17e, 21, 30, and 45, and 256B.434, subdivisions 4f and 4j, must be added to the total hold harmless rate in effect on the first of January, April, July, or October after project completion.

(c) Effective January 1, 2020, rate adjustments under Minnesota Statutes 2018, section 256R.25, paragraphs (f) to (h) from previous rate years shall be included in the total hold harmless rate.

(d) This subdivision expires effective January 1, 2026.

Subd. 8. **Phase out of hold harmless rate.** (a) For a nursing facility that has a higher total hold harmless rate than the rate calculated in section 256R.265, the nursing facility must receive 100 percent of the total hold harmless rate for the rate year beginning January 1, 2020.

(b) For rate years beginning January 1, 2021, to January 1, 2024, the property payment rate is a blending of the total hold harmless rate and the property rate determined in section 256R.265, plus any adjustments issued for construction projects between appraisals, if a higher rate results. If not, the property payment rate is determined according to section 256R.265.

(c) For the rate year beginning January 1, 2021, for eligible nursing facilities, the property payment rate is 80 percent of the total hold harmless rate and 20 percent of the property payment rate calculated in section 256R.265.

(d) For the rate year beginning January 1, 2022, for eligible nursing facilities, the property payment rate is 60 percent of the total hold harmless rate and 40 percent of the property payment rate calculated in section 256R.265.

(e) For the rate year beginning January 1, 2023, for eligible nursing facilities, the property payment rate is 40 percent of the total hold harmless rate and 60 percent of the property payment rate calculated in section 256R.265.

(f) For the rate year beginning January 1, 2024, for eligible nursing facilities, the property payment rate is 20 percent of the total hold harmless rate and 80 percent of the property payment rate calculated in section 256R.265.

(g) For rate years beginning January 1, 2025, and thereafter, the property payment rate is as calculated under section 256R.265.

(h) This subdivision expires effective January 1, 2026.

Sec. 26. **[256R.261] NURSING FACILITY PROPERTY RATE DEFINITIONS.**

Subdivision 1. **Definitions.** For purposes of sections 256R.26 to 256R.27, the following terms have the meanings given them.

Subd. 2. **Addition.** "Addition" means an extension, enlargement, or expansion of the nursing facility for the purpose of increasing the number of licensed beds or improving resident care.

Subd. 3. **Appraisal.** "Appraisal" means an evaluation of the nursing facility's physical real estate conducted by a property appraisal firm selected by the commissioner to establish the valuation of a building and fixed equipment.

Subd. 4. **Building.** "Building" means the physical plant and fixed equipment used directly for resident care and licensed under chapter 144A or sections 144.50 to 144.56. Building excludes buildings or portions of buildings used by central, affiliated, or corporate offices.

Subd. 5. **Commercial valuation system.** "Commercial valuation system" means a commercially available building valuation system selected by the commissioner.

Subd. 6. **Depreciable movable equipment.** "Depreciable movable equipment" means the standard movable care equipment and support service equipment generally used in nursing facilities. Depreciable movable equipment includes equipment specified in the major movable equipment table of the depreciation guidelines. The general characteristics of this equipment are: (1) a relatively fixed location in the building; (2) capable of being moved as distinguished from building equipment; (3) a unit cost sufficient to justify ledger control; and (4) sufficient size and identity to make control feasible by means of identification tags.

Subd. 7. **Depreciated replacement cost or DRC.** "Depreciated replacement cost" or "DRC" means the depreciated replacement cost determined by an appraisal using the commercial valuation system. DRC excludes costs related to parking structures.

Subd. 8. **Depreciation expense.** "Depreciation expense" means the portion of a capital asset deemed to be consumed or expired over the life of the asset.

Subd. 9. **Depreciation guidelines.** "Depreciation guidelines" means the most recent publication of "Estimated Useful Lives of Depreciable Hospital Assets" issued by the American Hospital Association.

Subd. 10. **Equipment allowance.** "Equipment allowance" means the component of the property-related payment rate which is a payment for the use of depreciable movable equipment.

Subd. 11. **Fair rental value system.** "Fair rental value system" means a system that establishes a price for the use of a space based on an appraised value of the property. The price is established without consideration of the actual accounting cost to construct or remodel the property. The price is the nursing facility value, subject to limits, multiplied by an established rental rate.

Subd. 12. **Fixed equipment.** "Fixed equipment" means equipment affixed to the building and not subject to transfer, including but not limited to wiring, electrical fixtures, plumbing, elevators, and heating and air conditioning systems.

Subd. 13. **Land improvement.** "Land improvement" means improvement to the land surrounding the nursing facility directly used for nursing facility operations as specified in the land improvements table of the depreciation guidelines. Land improvement includes construction of auxiliary buildings including sheds, garages, storage buildings, and parking structures.

Subd. 14. **Rental rate.** "Rental rate" means the percentage applied to the allowable value of the building and attached fixtures per year in the property payment calculation as determined by the commissioner.

Subd. 15. **Shared area.** "Shared area" means square footage that a nursing facility shares with a non-nursing facility operation to provide a support service.

Subd. 16. **Threshold project.** "Threshold project" means additions to a building or fixed equipment that exceed the costs specified in section 256R.26, subdivision 5, paragraph (b). Threshold projects exclude land, land improvements, and depreciable movable equipment purchases.

Subd. 17. **Undepreciated replacement cost or URC.** "Undepreciated replacement cost" or "URC" means the undepreciated replacement cost determined by the appraisal for building and attached fixtures using a commercial valuation system. URC excludes costs related to parking structures.

Subd. 18. **Undepreciated replacement cost (URC) per bed limit.** "Undepreciated replacement cost (URC) per bed limit" means the maximum allowed URC per nursing facility bed as established by the commissioner based on values across the industry and compared to an industry standard for reasonableness.

Sec. 27. **[256R.265] PROPERTY RATE CALCULATION UNDER FAIR RENTAL VALUE SYSTEM.**

Subdivision 1. **Square feet per bed limit.** The square feet per bed limit is calculated as follows:

(1) the URC of the nursing facility from the appraisal is divided by the total allowable square feet;

(2) the total allowable square feet per bed is calculated by dividing the actual square feet from the appraisal, after adjustment for non-nursing facility area, by the number of licensed beds three months prior to the beginning of the rate year limited to the following maximum. The allowable square feet maximum is 800 square feet per bed plus 25 percent of the square feet over 800 up to 1,200 square feet per bed. Square feet over 1,200 square feet per bed is not recognized; and

(3) the total allowable square feet per bed in clause (2) is multiplied by the amount in clause (1) and by the number of licensed beds three months prior to the beginning of the rate year to determine the square feet per bed limit.

Subd. 2. **Total URC limit.** The total URC limit is calculated as follows:

(1) the square feet per bed limit as determined in subdivision 1 is divided by the number of licensed beds three months prior to the beginning of the rate year to determine allowable URC per bed for each nursing facility, adjusted for square feet limitation;

(2) the allowable URC per bed, adjusted for square feet limitation, for all nursing facilities is placed in an array annually to determine the value at the 75th percentile. This is the limit for the URC per bed for non-single beds;

(3) the value determined in clause (2) is multiplied by 115 percent to determine the limit for the URC per bed for single beds;

(4) the number of non-single-licensed beds three months prior to the beginning of the rate year is multiplied by the amount in clause (2);

(5) the number of single-licensed beds three months prior to the beginning of the rate year is multiplied by the amount in clause (3); and

(6) the amounts in clauses (4) and (5) are summed to determine the total URC limit;

Subd. 3. **Calculation of total property rate.** The total property rate is calculated as follows:

(1) the lower of the allowable URC based on square feet per bed limit as determined under subdivision 1 or the total URC limit in subdivision 2 is the final allowed URC;

(2) the final allowed URC determined in clause (1) is divided by the URC from the appraisal to determine the allowed percentage. The allowed percentage is multiplied by the depreciated replacement value from the appraisal, adjusted for non-nursing facility area, to determine the final allowed depreciated replacement value;

(3) the number of licensed beds three months prior to the beginning of the rate year is multiplied by $5,305 to determine reimbursement for land and land improvements. There is no separate addition to the property rate for parking structures;

(4) the values in clauses (2) and (3) are summed and then multiplied by the rental rate of 5.5 percent to determine allowable property reimbursement;

(5) the allowable property reimbursement determined in clause (4) is divided by 90 percent of capacity days to determine the building property rate. Capacity days are determined by multiplying the number of licensed beds three months prior to the beginning of the report year by 365;

(6) for the rate year beginning January 1, 2020, the equipment allowance is $2.77 per resident day. For the rate year beginning January 1, 2021, the equipment allowance must be adjusted annually for inflation. The index for the inflation adjustment must be based on the change in the United States All Items Consumer Price Index (CPI-U) forecasted by the Reports and Forecasts Division of the Department of Human Services in the third quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined; and

(7) the sum of the building property rate and the equipment allowance is the total property rate.

Sec. 28. **[256R.27] INTERIM AND SETTLE UP PAYMENT RATES.**

Subdivision 1. **Generally.** (a) The commissioner shall determine the interim payment rates and settle up payment rates for a newly constructed nursing facility, or a nursing facility with an increase in licensed capacity of 50 percent or more, according to subdivisions 2 and 3.

(b) The nursing facility must submit a written application to the commissioner to receive interim payment rates. In its application, the nursing facility must state any reasons for noncompliance with this chapter.

(c) The effective date of the interim payment rates is the earlier of either the first day a resident is admitted to the newly constructed nursing facility or the date the nursing facility bed is certified for the medical assistance program. The interim payment rates must not be in effect for more than 17 months.

(d) The nursing facility must continue to receive the interim payment rates until the settle up payment rates are determined under subdivision 3.

(e) For the 15-month period following the settle up reporting period, the settle up payment rates must be determined according to subdivision 3, paragraph (c).

(f) The settle up payment rates are effective retroactively to the beginning of the interim cost reporting period and are effective until the end of the interim rate period.

(g) The total operating and external fixed costs payment rate for the rate year beginning January 1 following the 15-month period in paragraph (e) must be determined under this chapter.

Subd. 2. **Determination of interim payment rates.** (a) The nursing facility shall submit an interim cost report in a format similar to the Minnesota Statistical and Cost Report and other supporting information as required by this chapter for the reporting year in which the nursing facility plans to begin operation at least 60 days before the first day a resident is admitted to the newly constructed nursing facility bed. The interim cost report must include the nursing facility's anticipated interim costs and anticipated interim resident days for each resident class in the interim cost report. The anticipated interim resident days for each resident class is multiplied by the weight for that resident class to determine the anticipated interim standardized days as defined in section 256R.02, subdivision 50, and resident days as defined in section 256R.02, subdivision 45, for the reporting period.

(b) The interim total operating payment rate is determined according to this section, except that:

(1) the anticipated interim costs and anticipated interim resident days reported on the interim cost report and the anticipated interim standardized days as defined by section 256R.02, subdivision 50, must be used for the interim;

(2) the commissioner shall use anticipated interim costs and anticipated interim standardized days in determining the allowable historical direct care cost per standardized day as determined under section 256R.23, subdivision 2;

(3) the commissioner shall use anticipated interim costs and anticipated interim resident days in determining the allowable historical other care-related cost per resident day as determined under section 256R.23, subdivision 3;

(4) the commissioner shall use anticipated interim costs and anticipated interim resident days to determine the allowable historical external fixed costs per day under section 256R.25, paragraphs (b) to (k);

(5) the total care-related payment rate limits established in section 256R.23, subdivision 5, and in effect at the beginning of the interim period, must be increased by ten percent; and

(6) the other operating payment rate as determined under section 256R.24 in effect for the rate year must be used for the other operating cost per day.

Subd. 3. **Determination of settle up payment rates.** (a) When the interim payment rates begin between May 1 and September 30, the nursing facility shall file settle up cost reports for the period from the beginning of the interim payment rates through September 30 of the following year.

(b) When the interim payment rates begin between October 1 and April 30, the nursing facility shall file settle up cost reports for the period from the beginning of the interim payment rates to the first September 30 following the beginning of the interim payment rates.

(c) The settle up total operating payment rate is determined according to this section, except that:

(1) the allowable costs and resident days reported on the settle up cost report and the standardized days as defined by section 256R.02, subdivision 50, must be used for the interim and settle-up period;

(2) the commissioner shall use the allowable costs and standardized days in clause (1) to determine the allowable historical direct care cost per standardized day as determined under section 256R.23, subdivision 2;

(3) the commissioner shall use the allowable costs and the allowable resident days to determine both the allowable historical other care-related cost per resident day as determined under section 256R.23, subdivision 3;

(4) the commissioner shall use the allowable costs and the allowable resident days to determine the allowable historical external fixed costs per day under section 256R.25, paragraphs (b) to (k);

(5) the total care-related payment limits established in section 256R.23, subdivision 5, are the limits for the settle up reporting periods. If the interim period includes more than one July 1 date, the commissioner shall use the total care-related payment rate limit established in section 256R.23, subdivision 5, increased by ten percent for the second July 1 date; and

(6) the other operating payment rate as determined under section 256R.24 in effect for the rate year must be used for the other operating cost per day.

Sec. 29. **[256R.28] INTERIM AND SETTLE UP PAYMENT RATES FOR NEW OWNERS AND OPERATORS.**

Subdivision 1. **Generally.** (a) A nursing facility that undergoes a change of ownership or operator resulting in a change of licensee, as determined by the commissioner of health under chapter 144A, after December 31, 2019, must receive interim payment rates and settle up payment rates according to this section.

(b) The effective date of the interim rates is the effective date of the new license. The interim payment rates must not be in effect for more than 26 months.

(c) The nursing facility must continue to receive the interim payment rates until the settle up payment rates are determined under subdivision 3.

(d) The settle up payment rates are effective retroactively to the effective date of the new license and remain effective until the end of the interim rate period.

(e) For the 15-month period following the settle up payment, rates must be determined according to subdivision 3, paragraph (c).

(f) The total operating and external fixed costs payment rates for the rate year beginning January 1 following the 15-month period in paragraph (e) must be determined under section 256R.21.

Subd. 2. **Determination of interim payment rates.** The interim total payment rates must be the rates established under section 256R.21.

Subd. 3. **Determination of settle up payment rates.** (a) When the interim payment rates begin between May 1 and September 30, the nursing facility shall file settle up cost reports for the period from the beginning of the interim payment rates through September 30 of the following year.

(b) When the interim payment rates begin between October 1 and April 30, the nursing facility shall file settle up cost reports for the period from the beginning of the interim payment rates to the first September 30 following the beginning of the interim payment rates.

(c) The settle up total payment rates are determined according to section 256R.21, except that the commissioner shall:

(1) use the allowable costs and the resident days from the settle up cost reports to determine the allowable external fixed costs payment rate; and

(2) use the allowable costs and the resident days from the settle up cost reports to determine the total care-related payment rate.

Sec. 30. Minnesota Statutes 2018, section 256R.44, is amended to read:

**256R.44 RATE ADJUSTMENT FOR PRIVATE ROOMS FOR MEDICAL NECESSITY.**

The amount paid for a private room is ~~111.5~~ 110 percent of the established total payment rate for a resident if the resident is a medical assistance recipient and the private room is considered a medical necessity for the resident or others who are affected by the resident's condition~~, except as provided in Minnesota Rules, part 9549.0060, subpart 11, item C~~. Conditions requiring a private room must be determined by the resident's attending physician and submitted to the commissioner for approval or denial by the commissioner on the basis of medical necessity.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 31. Minnesota Statutes 2018, section 256R.47, is amended to read:

**256R.47 RATE ADJUSTMENT FOR CRITICAL ACCESS NURSING FACILITIES.**

(a) The commissioner, in consultation with the commissioner of health, may designate certain nursing facilities as critical access nursing facilities. The designation shall be granted on a competitive basis, within the limits of funds appropriated for this purpose.

(b) The commissioner shall request proposals from nursing facilities every two years. Proposals must be submitted in the form and according to the timelines established by the commissioner. In selecting applicants to designate, the commissioner, in consultation with the commissioner of health, and with input from stakeholders, shall develop criteria designed to preserve access to nursing facility services in isolated areas, rebalance long-term care, and improve quality. To the extent practicable, the commissioner shall ensure an even distribution of designations across the state.

(c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing facilities designated as critical access nursing facilities:

(1) partial rebasing, with the commissioner allowing a designated facility operating payment rates being the sum of up to 60 percent of the operating payment rate determined in accordance with section 256R.21, subdivision 3, and at least 40 percent, with the sum of the two portions being equal to 100 percent, of the operating payment rate that would have been allowed had the facility not been designated. The commissioner may adjust these percentages by up to 20 percent and may approve a request for less than the amount allowed;

(2) enhanced payments for leave days. Notwithstanding section 256R.43, upon designation as a critical access nursing facility, the commissioner shall limit payment for leave days to 60 percent of that nursing facility's total payment rate for the involved resident, and shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 90 percent;

(3) two designated critical access nursing facilities, with up to 100 beds in active service, may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner of health shall consider each waiver request independently based on the criteria under Minnesota Rules, part 4658.0040;

(4) the minimum threshold under section 256B.431, subdivision 15, paragraph (e), shall be 40 percent of the amount that would otherwise apply; and

(5) the quality-based rate limits under section 256R.23, subdivisions 5 to 7, apply to designated critical access nursing facilities.

(d) Designation of a critical access nursing facility is for a period of two years, after which the benefits allowed under paragraph (c) shall be removed. Designated facilities may apply for continued designation.

(e) This section is suspended and no state or federal funding shall be appropriated or allocated for the purposes of this section from January 1, 2016, ~~to December 31, 2019.~~ through December 31, 2023.

Sec. 32. Minnesota Statutes 2018, section 256R.50, subdivision 6, is amended to read:

Subd. 6. **Determination of rate adjustment.** (a) If the amount determined in subdivision 5 is less than or equal to the amount determined in subdivision 4, the commissioner shall allow a total payment rate equal to the amount used in subdivision 5, clause (3).

(b) If the amount determined in subdivision 5 is greater than the amount determined in subdivision 4, the commissioner shall allow a rate with a case mix index of 1.0 that when used in subdivision 5, clause (3), results in the amount determined in subdivision 5 being equal to the amount determined in subdivision 4.

(c) If the commissioner relies upon provider estimates in subdivision 5, clause (1) or (2), then annually, for three years after the rates determined in this section take effect, the commissioner shall determine the accuracy of the alternative factors of medical assistance case load and the facility average case mix index used in this section and shall reduce the total payment rate if the factors used result in medical assistance costs exceeding the amount

in subdivision 4. If the actual medical assistance costs exceed the estimates by more than five percent, the commissioner shall also recover the difference between the estimated costs in subdivision 5 and the actual costs according to section 256B.0641. The commissioner may require submission of data from the receiving facility needed to implement this paragraph.

(d) When beds approved for relocation are put into active service at the destination facility, rates determined in this section must be adjusted by any adjustment amounts that were implemented after the date of the letter of approval.

(e) Rate adjustments determined under this subdivision expire after three full rate years following the effective date of the rate adjustment. This subdivision expires when the final rate adjustment determined under this subdivision expires.

Sec. 33. **DIRECTION TO COMMISSIONER; MORATORIUM EXCEPTION FUNDING.**

In fiscal year 2020, the commissioner of health may approve moratorium exception projects under Minnesota Statutes, section 144A.073, for which the full annualized state share of medical assistance costs does not exceed $1,500,000 plus any carryover of previous appropriations for this purpose.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 34. **REVISOR INSTRUCTION.**

In Minnesota Statutes, the revisor of statutes shall renumber the nursing facility contracting provisions that are currently coded as section 256B.434, subdivisions 1 and 3, as amended by this act, as a section in chapter 256R and revise any statutory cross-references consistent with that recoding.

Sec. 35. **REPEALER.**

(a) Minnesota Statutes 2018, sections 144A.071, subdivision 4d; 256R.40; and 256R.41, are repealed effective July 1, 2019.

(b) Minnesota Statutes 2018, sections 256B.431, subdivisions 3a, 3f, 3g, 3i, 10, 13, 15, 16, 17, 17a, 17c, 17d, 17e, 18, 21, 22, 30, and 45; 256B.434, subdivisions 4, 4f, 4i, and 4j; and 256R.36, and Minnesota Rules, parts 9549.0057; and 9549.0060, subparts 4, 5, 6, 7, 10, 11, and 14, are repealed effective January 1, 2020.

(c) Minnesota Statutes 2018, section 256B.434, subdivisions 6 and 10, are repealed effective the day following final enactment.

## ARTICLE 5
## DISABILITY SERVICES

Section 1. Minnesota Statutes 2018, section 237.50, subdivision 4a, is amended to read:

Subd. 4a. **Deaf.** "Deaf" means a hearing loss of such severity that the ~~individual~~ person must depend primarily upon visual communication such as writing, lip reading, sign language, and gestures.

**EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 2. Minnesota Statutes 2018, section 237.50, is amended by adding a subdivision to read:

Subd. 4c. **Discounted telecommunications or Internet services.** "Discounted telecommunications or Internet services" means private, nonprofit, and public programs intended to subsidize or reduce the monthly costs of telecommunications or Internet services for a person who meets a program's eligibility requirements.

**EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 3. Minnesota Statutes 2018, section 237.50, subdivision 6a, is amended to read:

Subd. 6a. **Hard-of-hearing.** "Hard-of-hearing" means a hearing loss resulting in a functional limitation, but not to the extent that the ~~individual~~ person must depend primarily upon visual communication in all interactions.

**EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 4. Minnesota Statutes 2018, section 237.50, is amended by adding a subdivision to read:

Subd. 6b. **Interconnectivity product.** "Interconnectivity product" means a device, accessory, or application for which the primary function is use with a telecommunications device. Interconnectivity product may include a cell phone amplifier, hearing aid streamer,

Bluetooth-enabled device that connects to a wireless telecommunications device, advanced communications application for a smartphone, or other applicable technology.

**EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 5. Minnesota Statutes 2018, section 237.50, subdivision 10a, is amended to read:

Subd. 10a. **Telecommunications device.** "Telecommunications device" means a device that (1) allows a person with a communication disability to have access to telecommunications services as defined in subdivision 13, and (2) is specifically selected by the Department of Human Services for its capacity to allow persons with communication disabilities to use telecommunications services in a manner that is functionally equivalent to the ability of ~~an individual~~ a person who does not have a communication disability. A telecommunications device may include a ring signaler, an amplified telephone, a hands-free telephone, a text telephone, a captioned telephone, a wireless device, a device that produces Braille output for use with a telephone, and any other device the Department of Human Services deems appropriate.

**EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 6. Minnesota Statutes 2018, section 237.50, subdivision 11, is amended to read:

Subd. 11. **Telecommunications Relay Services.** "Telecommunications Relay Services" or "TRS" means the telecommunications transmission services required under Federal Communications Commission regulations at Code of Federal Regulations, title 47, sections 64.604 to 64.606. TRS allows ~~an individual~~ a person who has a communication disability to use telecommunications services in a manner that is functionally equivalent to the ability of ~~an individual~~ a person who does not have a communication disability.

**EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 7. Minnesota Statutes 2018, section 237.51, subdivision 1, is amended to read:

Subdivision 1. **Creation.** (a) The commissioner of commerce shall:

(1) administer through interagency agreement with the commissioner of human services a program to distribute telecommunications devices and interconnectivity products to eligible persons who have communication disabilities; and

(2) contract with one or more qualified vendors that serve persons who have communication disabilities to provide telecommunications relay services.

(b) For purposes of sections 237.51 to 237.56, the Department of Commerce and any organization with which it contracts pursuant to this section or section 237.54, subdivision 2, are not telephone companies or telecommunications carriers as defined in section 237.01.

**EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 8. Minnesota Statutes 2018, section 237.51, subdivision 5a, is amended to read:

Subd. 5a. **Commissioner of human services duties.** (a) In addition to any duties specified elsewhere in sections 237.51 to 237.56, the commissioner of human services shall:

(1) define economic hardship, special needs, and household criteria so as to determine the priority of eligible applicants for initial distribution of devices and products and to determine circumstances necessitating provision of more than one telecommunications device per household;

(2) establish a method to verify eligibility requirements;

(3) establish specifications for telecommunications devices and interconnectivity products to be provided under section 237.53, subdivision 3;

(4) inform the public and specifically persons who have communication disabilities of the program; ~~and~~

(5) provide devices and products based on the assessed need of eligible applicants~~.~~; and

(6) assist a person with completing an application for discounted telecommunications or Internet services.

(b) The commissioner may establish an advisory board to advise the department in carrying out the duties specified in this section and to advise the commissioner of commerce in carrying out duties under section 237.54. If so established, the advisory board must include, at a minimum, the following persons:

(1) at least one member who is deaf;

(2) at least one member who has a speech disability;

(3) at least one member who has a physical disability that makes it difficult or impossible for the person to access telecommunications services; and

(4) at least one member who is hard-of-hearing.

(c) The membership terms, compensation, and removal of members and the filling of membership vacancies are governed by section 15.059. Advisory board meetings shall be held at the discretion of the commissioner.

**EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 9. Minnesota Statutes 2018, section 237.52, subdivision 5, is amended to read:

Subd. 5. **Expenditures.** (a) Money in the fund may only be used for:

(1) expenses of the Department of Commerce, including personnel cost, public relations, advisory board members' expenses, preparation of reports, and other reasonable expenses not to exceed ten percent of total program expenditures;

(2) reimbursing the commissioner of human services for purchases made or services provided pursuant to section 237.53; and

(3) contracting for the provision of TRS required by section 237.54.

(b) All costs directly associated with the establishment of the program, the purchase and distribution of telecommunications devices, and interconnectivity products, and the provision of TRS are either reimbursable or directly payable from the fund after authorization by the commissioner of commerce. The commissioner of commerce shall contract with one or more TRS providers to indemnify the telecommunications service providers for any fines imposed by the Federal Communications Commission related to the failure of the relay service to comply with federal service standards. Notwithstanding section 16A.41, the commissioner may advance money to the TRS providers if the providers establish to the commissioner's satisfaction that the advance payment is necessary for the provision of the service. The advance payment may be used only for working capital reserve for the operation of the service. The advance payment must be offset or repaid by the end of the contract fiscal year together with interest accrued from the date of payment.

**EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 10. Minnesota Statutes 2018, section 237.53, is amended to read:

**237.53 TELECOMMUNICATIONS ~~DEVICE~~ DEVICES AND INTERCONNECTIVITY PRODUCTS.**

Subdivision 1. **Application.** A person applying for a telecommunications device or interconnectivity product under this section must apply to the program administrator on a form prescribed by the Department of Human Services.

Subd. 2. **Eligibility.** To be eligible to obtain a telecommunications device or interconnectivity product under this section, a person must:

(1) be able to benefit from and use the equipment for its intended purpose;

(2) have a communication disability;

(3) be a resident of the state;

(4) be a resident in a household that has a median income at or below the applicable median household income in the state, except a person who is deafblind applying for a Braille device may reside in a household that has a median income no more than 150 percent of the applicable median household income in the state; and

(5) be a resident in a household that has telecommunications service or that has made application for service and has been assigned a telephone number; or a resident in a residential care facility, such as a nursing home or group home where telecommunications service is not included as part of overall service provision.

Subd. 2a. **Assessment of needs.** After a person is determined to be eligible for the program, the commissioner of human services shall assess the person's telecommunications needs to determine: (1) the type of telecommunications device that provides the person with functionally equivalent access to telecommunications services; and (2) appropriate interconnectivity products for the person.

Subd. 3. **Distribution.** The commissioner of human services shall (1) purchase ~~and distribute~~ a sufficient number of telecommunications devices and interconnectivity products so that each eligible household receives appropriate devices and products as determined under section 237.51, subdivision 5a~~. The commissioner of human services shall~~, and (2) distribute the devices and products to eligible households free of charge.

Subd. 4. **Training; information; maintenance.** The commissioner of human services shall maintain the telecommunications devices and interconnectivity products until the warranty period expires, and provide training, without charge, to first-time users of the

devices. and products. The commissioner shall provide information about assistive communications devices and products that may benefit a program participant and about where a person may obtain or purchase assistive communications devices and products. Assistive communications devices and products include a pocket talker for a person who is hard-of-hearing, a communication board for a person with a speech disability, a one-to-one video communication application for a person who is deaf, and other devices and products designed to facilitate effective communication for a person with a communication disability.

Subd. 6. **Ownership.** Telecommunications devices and interconnectivity products purchased pursuant to subdivision 3, clause (1), are the property of the state of Minnesota. Policies and procedures for the return of distributed devices ~~from individuals who withdraw from the program or whose eligibility status changes~~ and products shall be determined by the commissioner of human services.

Subd. 7. **Standards.** The telecommunications devices distributed under this section must comply with the electronic industries alliance standards and be approved by the Federal Communications Commission. The commissioner of human services must provide each eligible person a choice of several models of devices, the retail value of which may not exceed $600 for a text telephone, and a retail value of $7,000 for a Braille device, or an amount authorized by the Department of Human Services for all other telecommunications devices ~~and~~, auxiliary equipment, and interconnectivity products it deems cost-effective and appropriate to distribute according to sections 237.51 to 237.56.

Subd. 9. **Discounted telecommunications or Internet services assistance.** The commissioner of human services shall assist a person who is applying for telecommunication devices and products in applying for discounted telecommunications or Internet services.

**EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 11. Minnesota Statutes 2018, section 245C.03, is amended by adding a subdivision to read:

Subd. 13. **Early intensive developmental and behavioral intervention providers.** The commissioner shall conduct background studies according to this chapter when initiated by an early intensive developmental and behavioral intervention provider under section 256B.0949.

Sec. 12. Minnesota Statutes 2018, section 245C.10, is amended by adding a subdivision to read:

Subd. 14. **Early intensive developmental and behavioral intervention providers.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 13, for the purposes of early intensive developmental and behavioral intervention under section 256B.0949, through a fee of no more than $32 per study charged to the enrolled agency. Fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 13. Minnesota Statutes 2018, section 245D.03, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of home and community-based services to persons with disabilities and persons age 65 and older pursuant to this chapter. The licensing standards in this chapter govern the provision of basic support services and intensive support services.

(b) Basic support services provide the level of assistance, supervision, and care that is necessary to ensure the health and welfare of the person and do not include services that are specifically directed toward the training, treatment, habilitation, or rehabilitation of the person. Basic support services include:

(1) in-home and out-of-home respite care services as defined in section 245A.02, subdivision 15, and under the brain injury, community alternative care, community access for disability inclusion, developmental disability, and elderly waiver plans, excluding out-of-home respite care provided to children in a family child foster care home licensed under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care license holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7, and 8, or successor provisions; and section 245D.061 or successor provisions, which must be stipulated in the statement of intended use required under Minnesota Rules, part 2960.3000, subpart 4;

(2) adult companion services as defined under the brain injury, community access for disability inclusion, and elderly waiver plans, excluding adult companion services provided under the Corporation for National and Community Services Senior Companion Program established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

(3) personal support as defined under the developmental disability waiver plan;

(4) 24-hour emergency assistance, personal emergency response as defined under the community access for disability inclusion and developmental disability waiver plans;

(5) night supervision services as defined under the brain injury waiver plan;

(6) homemaker services as defined under the community access for disability inclusion, brain injury, community alternative care, developmental disability, and elderly waiver plans, excluding providers licensed by the Department of Health under chapter 144A and those providers providing cleaning services only; ~~and~~

(7) individual community living support under section 256B.0915, subdivision 3j~~.~~; and

(8) individualized home supports services as defined under the brain injury, community alternative care, and community access for disability inclusion, and developmental disability waiver plans.

(c) Intensive support services provide assistance, supervision, and care that is necessary to ensure the health and welfare of the person and services specifically directed toward the training, habilitation, or rehabilitation of the person. Intensive support services include:

(1) intervention services, including:

(i) behavioral support services as defined under the brain injury and community access for disability inclusion waiver plans;

(ii) in-home or out-of-home crisis respite services as defined under the developmental disability waiver plan; and

(iii) specialist services as defined under the current developmental disability waiver plan;

(2) in-home support services, including:

(i) in-home family support and supported living services as defined under the developmental disability waiver plan;

(ii) independent living services training as defined under the brain injury and community access for disability inclusion waiver plans;

(iii) semi-independent living services; ~~and~~

~~(iv) individualized home supports services as defined under the brain injury, community alternative care, and community access for disability inclusion waiver plans;~~

(iv) individualized home support with training services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans; and

(v) individualized home support with family training services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans;

(3) residential supports and services, including:

(i) supported living services as defined under the developmental disability waiver plan provided in a family or corporate child foster care residence, a family adult foster care residence, a community residential setting, or a supervised living facility;

(ii) foster care services as defined in the brain injury, community alternative care, and community access for disability inclusion waiver plans provided in a family or corporate child foster care residence, a family adult foster care residence, or a community residential setting; ~~and~~

(iii) community residential services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans provided in a corporate child foster care residence, a community residential setting, or a supervised living facility;

(iv) family residential services as defined in the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans provided in a family child foster care residence or a family adult foster care residence; and

(v) residential services provided to more than four persons with developmental disabilities in a supervised living facility, including ICFs/DD;

(4) day services, including:

(i) structured day services as defined under the brain injury waiver plan;

(ii) day services under sections 252.41 to 252.46, and as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans;

(iii) day training and habilitation services under sections 252.41 to 252.46, and as defined under the developmental disability waiver plan; and

~~(iii)~~ (iv) prevocational services as defined under the brain injury ~~and~~, community alternative care, community access for disability inclusion, and developmental disability waiver plans; and

(5) employment exploration services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans;

(6) employment development services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans; ~~and~~

(7) employment support services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans~~.~~; and

(8) integrated community support as defined under the brain injury and community access for disability inclusion waiver plans beginning January 1, 2021, and community alternative care and developmental disability waiver plans beginning January 1, 2023.

**EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 14. Minnesota Statutes 2018, section 245D.071, subdivision 1, is amended to read:

Subdivision 1. **Requirements for intensive support services.** Except for services identified in section 245D.03, subdivision 1, paragraph (c), clauses (1) and (2), item (ii), a license holder providing intensive support services identified in section 245D.03, subdivision 1, paragraph (c), must comply with the requirements in this section and section 245D.07, subdivisions 1, 1a, and 3. Services identified in section 245D.03, subdivision 1, paragraph (c), clauses (1) and (2), item (ii), must comply with the requirements in section 245D.07, subdivision 2.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 15. **[245D.12] INTEGRATED COMMUNITY SUPPORTS; SETTING CAPACITY REPORT.**

(a) The license holder providing integrated community support, as defined in section 245D.03, subdivision 1, paragraph (c), clause (8), must submit a setting capacity report to the commissioner to ensure the identified location of service delivery meets the criteria of the home and community-based service requirements as specified in section 256B.492.

(b) The license holder shall provide the setting capacity report on the forms and in the manner prescribed by the commissioner. The report must include:

(1) the address of the multifamily housing building where the license holder delivers integrated community supports and owns, leases, or has a direct or indirect financial relationship with the property owner;

(2) the total number of living units in the multifamily housing building described in clause (1) where integrated community supports are delivered;

(3) the total number of living units in the multifamily housing building described in clause (1), including the living units identified in clause (2); and

(4) the percentage of living units that are controlled by the license holder in the multifamily housing building by dividing clause (2) by clause (3).

(c) Only one license holder may deliver integrated community supports at the address of the multifamily housing building.

**EFFECTIVE DATE.** This section is effective upon the date of federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 16. Minnesota Statutes 2018, section 252.27, subdivision 2a, is amended to read:

Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child, including a child determined eligible for medical assistance without consideration of parental income, must contribute to the cost of services used by making monthly payments on a sliding scale based on income, unless the child is married or has been married, parental rights have been terminated, or the child's adoption is subsidized according to chapter 259A or through title IV-E of the Social Security Act. The parental contribution is a partial or full payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating, rehabilitation, maintenance, and personal care services as defined in United States Code, title 26, section 213, needed by the child with a chronic illness or disability.

(b) For households with adjusted gross income equal to or greater than 275 percent of federal poverty guidelines, the parental contribution shall be computed by applying the following schedule of rates to the adjusted gross income of the natural or adoptive parents:

(1) if the adjusted gross income is equal to or greater than 275 percent of federal poverty guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at ~~1.94~~ 1.65 percent of adjusted gross income at 275 percent of federal poverty guidelines and increases to ~~5.29~~ 4.5 percent of adjusted gross income for those with adjusted gross income up to 545 percent of federal poverty guidelines;

(2) if the adjusted gross income is greater than 545 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be ~~5.29~~ 4.5 percent of adjusted gross income;

(3) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 975 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at ~~5.29~~ 4.5 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to ~~7.05~~ 5.99 percent of adjusted gross income for those with adjusted gross income up to 975 percent of federal poverty guidelines; and

(4) if the adjusted gross income is equal to or greater than 975 percent of federal poverty guidelines, the parental contribution shall be ~~8.81~~ 7.49 percent of adjusted gross income.

If the child lives with the parent, the annual adjusted gross income is reduced by $2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents, including the child receiving services. Adjustments in the contribution amount due to annual changes in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

(d) For purposes of paragraph (b), "income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form, except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds have been used to purchase a home shall not be counted as income.

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted. All reimbursements must include a notice that the amount reimbursed may be taxable income

if the parent paid for the parent's fees through an employer's health care flexible spending account under the Internal Revenue Code, section 125, and that the parent is responsible for paying the taxes owed on the amount reimbursed.

(f) The monthly contribution amount must be reviewed at least every 12 months; when there is a change in household size; and when there is a loss of or gain in income from one month to another in excess of ten percent. The local agency shall mail a written notice 30 days in advance of the effective date of a change in the contribution amount. A decrease in the contribution amount is effective in the month that the parent verifies a reduction in income or change in household size.

(g) Parents of a minor child who do not live with each other shall each pay the contribution required under paragraph (a). An amount equal to the annual court-ordered child support payment actually paid on behalf of the child receiving services shall be deducted from the adjusted gross income of the parent making the payment prior to calculating the parental contribution under paragraph (b).

(h) The contribution under paragraph (b) shall be increased by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child. For purposes of this section, "available" means the insurance is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income. For purposes of this section, "insurance" means health and accident insurance coverage, enrollment in a nonprofit health service plan, health maintenance organization, self-insured plan, or preferred provider organization.

Parents who have more than one child receiving services shall not be required to pay more than the amount for the child with the highest expenditures. There shall be no resource contribution from the parents. The parent shall not be required to pay a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

(i) The contribution under paragraph (b) shall be reduced by $300 per fiscal year if, in the 12 months prior to July 1:

(1) the parent applied for insurance for the child;

(2) the insurer denied insurance;

(3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a complaint or appeal, in writing, to the commissioner of health or the commissioner of commerce, or litigated the complaint or appeal; and

(4) as a result of the dispute, the insurer reversed its decision and granted insurance.

For purposes of this section, "insurance" has the meaning given in paragraph (h).

A parent who has requested a reduction in the contribution amount under this paragraph shall submit proof in the form and manner prescribed by the commissioner or county agency, including, but not limited to, the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14.

Sec. 17. Minnesota Statutes 2018, section 252.275, subdivision 3, is amended to read:

Subd. 3. **Reimbursement.** Counties shall be reimbursed for all expenditures made pursuant to subdivision 1 at a rate of ~~70~~ 85 percent, up to the allocation determined pursuant to subdivisions 4 and 4b. However, the commissioner shall not reimburse costs of services for any person if the costs exceed the state share of the average medical assistance costs for services provided by intermediate care facilities for a person with a developmental disability for the same fiscal year, and shall not reimburse costs of a onetime living allowance for any person if the costs exceed $1,500 in a state fiscal year. The commissioner may make payments to each county in quarterly installments. The commissioner may certify an advance of up to 25 percent of the allocation. Subsequent payments shall be made on a reimbursement basis for reported expenditures and may be adjusted for anticipated spending patterns.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 18. Minnesota Statutes 2018, section 252.28, subdivision 1, is amended to read:

Subdivision 1. **Determinations; ~~redeterminations~~.** In conjunction with the appropriate ~~county~~ lead agency boards, the commissioner of human services shall determine~~, and shall redetermine at least every four years,~~ the need, ~~anticipated~~ growth ~~or~~, decline in need ~~until the next anticipated redetermination~~, location, size, and program services of public and private day training and habilitation services ~~for persons with developmental disabilities~~, structured day services, prevocational services, and adult day services for people with disabilities funded under medical assistance and the home and community-based services waivers under sections 256B.092 and 256B.49. This subdivision does not apply to

semi-independent living services and residential-based habilitation services provided to four or fewer persons at a single site funded as home and community-based services. A determination of need shall not be required for a change in ownership.

Sec. 19. Minnesota Statutes 2018, section 252.41, subdivision 3, is amended to read:

Subd. 3. **Day ~~training and habilitation~~ services for adults with ~~developmental~~ disabilities.** (a) "Day ~~training and habilitation~~ services for adults with ~~developmental~~ disabilities" means services that:

(1) include supervision, training, assistance, support, ~~center-based~~ facility-based work-related activities, or other community-integrated activities designed and implemented in accordance with the ~~individual service and individual habilitation plans~~ coordinated service and support plan and coordinated service and support plan addendum required under sections 245D.02, subdivision 4, paragraphs (b) and (c), and 256B.092, subdivision 1b, and Minnesota Rules, ~~parts~~ part 9525.0004 ~~to 9525.0036~~, subpart 12, to help an adult reach and maintain the highest possible level of independence, productivity, and integration into the community; ~~and~~

(2) include day support services, prevocational services, day training and habilitation services, structured day services, and adult day services as defined in Minnesota's federally approved disability waiver plans; and

(3) are provided by a vendor licensed under sections 245A.01 to 245A.16 ~~and~~, 245D.27 to 245D.31, 252.28, subdivision 2, and 252.41 to 252.46, and Minnesota Rules, parts 9525.1200 to 9525.1330, to provide day ~~training and habilitation~~ services.

(b) Day ~~training and habilitation~~ services reimbursable under this section do not include special education and related services as defined in the Education of the Individuals with Disabilities Act, United States Code, title 20, chapter 33, section 1401, clauses (6) and (17), or vocational services funded under section 110 of the Rehabilitation Act of 1973, United States Code, title 29, section 720, as amended.

(c) Day ~~training and habilitation~~ services do not include employment exploration, employment development, or employment support services as defined in the home and community-based services waivers for people with disabilities authorized under sections 256B.092 and 256B.49.

**EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 20. Minnesota Statutes 2018, section 252.41, subdivision 4, is amended to read:

Subd. 4. **Independence.** "Independence" means the extent to which persons with ~~developmental~~ disabilities exert control and choice over their own lives.

**EFFECTIVE DATE.** This section is effective January 1, 2021.

Sec. 21. Minnesota Statutes 2018, section 252.41, subdivision 5, is amended to read:

Subd. 5. **Integration.** "Integration" means that persons with ~~developmental~~ disabilities:

(1) use the same community resources that are used by and available to individuals who are not disabled;

(2) participate in the same community activities in which nondisabled individuals participate; and

(3) regularly interact and have contact with nondisabled individuals.

**EFFECTIVE DATE.** This section is effective January 1, 2021.

Sec. 22. Minnesota Statutes 2018, section 252.41, subdivision 6, is amended to read:

Subd. 6. **Productivity.** "Productivity" means that persons with ~~developmental~~ disabilities:

(1) engage in income-producing work designed to improve their income level, employment status, or job advancement; or

(2) engage in activities that contribute to a business, household, or community.

**EFFECTIVE DATE.** This section is effective January 1, 2021.

Sec. 23. Minnesota Statutes 2018, section 252.41, subdivision 7, is amended to read:

Subd. 7. **Regional center.** "Regional center" means any state-operated facility under the direct administrative authority of the commissioner that serves persons with ~~developmental~~ disabilities.

**EFFECTIVE DATE.** This section is effective January 1, 2021.

Sec. 24. Minnesota Statutes 2018, section 252.41, subdivision 9, is amended to read:

Subd. 9. **Vendor.** "Vendor" means a ~~nonprofit~~ legal entity that:

(1) is licensed under sections 245A.01 to 245A.16 ~~and~~, 245D.27 to 245D.31, 252.28, subdivision 2, and 252.41 to 252.46, and Minnesota Rules, parts 9525.1200 to 9525.1330,

to provide day ~~training and habilitation~~ services to adults with ~~developmental~~ disabilities; and

(2) does not have a financial interest in the legal entity that provides residential services to the same person or persons to whom it provides day ~~training and habilitation~~ services. This clause does not apply to regional treatment centers, state-operated, community-based programs operating according to section 252.50 until July 1, 2000, or vendors licensed prior to April 15, 1983.

**EFFECTIVE DATE.** This section is effective January 1, 2021.

Sec. 25. Minnesota Statutes 2018, section 252.42, is amended to read:

**252.42 SERVICE PRINCIPLES.**

The design and delivery of services eligible for reimbursement should reflect the following principles:

(1) services must suit a person's chronological age and be provided in the least restrictive environment possible, consistent with the needs identified in the person's ~~individual service and individual habilitation plans under~~ coordinated service and support plan and coordinated service and support plan addendum required under sections 256B.092, subdivision 1b, and 245D.02, subdivision 4, paragraphs (b) and (c), and Minnesota Rules, parts 9525.0004 ~~to 9525.0036~~, subpart 12;

(2) a person with a ~~developmental~~ disability whose individual ~~service and individual habilitation plans~~ coordinated service and support plans and coordinated service and support plan addendums authorize employment or employment-related activities shall be given the opportunity to participate in employment and employment-related activities in which nondisabled persons participate;

(3) a person with a ~~developmental~~ disability participating in work shall be paid wages commensurate with the rate for comparable work and productivity except as regional centers are governed by section 246.151;

(4) a person with a ~~developmental~~ disability shall receive services which include services offered in settings used by the general public and designed to increase the person's active participation in ordinary community activities;

(5) a person with a ~~developmental~~ disability shall participate in the patterns, conditions, and rhythms of everyday living and working that are consistent with the norms of the mainstream of society.

**EFFECTIVE DATE.** This section is effective January 1, 2021.

Sec. 26. Minnesota Statutes 2018, section 252.43, is amended to read:

**252.43 COMMISSIONER'S DUTIES.**

The commissioner shall supervise ~~county boards'~~ lead agencies' provision of day ~~training and habilitation~~ services to adults with ~~developmental~~ disabilities. The commissioner shall:

(1) determine the need for day ~~training and habilitation~~ services under section ~~252.28~~ 256B.4914;

(2) establish payment rates as provided under section 256B.4914;

(3) add transportation costs to the day services payment rate;

(4) adopt rules for the administration and provision of day ~~training and habilitation~~ services under ~~sections 252.41 to 252.46 and~~ sections 245A.01 to 245A.16 ~~and~~, 252.28, subdivision 2, and 252.41 to 252.46, and Minnesota Rules, parts 9525.1200 to 9525.1330;

~~(4)~~ (5) enter into interagency agreements necessary to ensure effective coordination and provision of day ~~training and habilitation~~ services;

~~(5)~~ (6) monitor and evaluate the costs and effectiveness of day ~~training and habilitation~~ services; and

~~(6)~~ (7) provide information and technical help to ~~county boards~~ lead agencies and vendors in their administration and provision of day ~~training and habilitation~~ services.

**EFFECTIVE DATE.** This section is effective January 1, 2021.

Sec. 27. Minnesota Statutes 2018, section 252.44, is amended to read:

**252.44 ~~COUNTY~~ LEAD AGENCY BOARD RESPONSIBILITIES.**

When the need for day ~~training and habilitation~~ services in a county or tribe has been determined under section 252.28, the board of commissioners for that ~~county~~ lead agency shall:

(1) authorize the delivery of services according to the ~~individual service and habilitation plans~~ coordinated service and support plans and coordinated service and support plan addendums required as part of the ~~county's~~ lead agency's provision of case management services under sections 256B.0913, subdivision 8; 256B.0915, subdivision 6; 256B.092, subdivision 1b; and 256B.49, subdivision 15, and Minnesota Rules, parts 9525.0004 to 9525.0036~~. For calendar years for which section 252.46, subdivisions 2 to 10, apply, the~~

~~county board shall not authorize a change in service days from the number of days authorized for the previous calendar year unless there is documentation for the change in the individual service plan. An increase in service days must also be supported by documentation that the goals and objectives assigned to the vendor cannot be met more economically and effectively by other available community services and that without the additional days of service the individual service plan could not be implemented in a manner consistent with the service principles in section 252.42~~;

(2) ensure that transportation is provided or arranged by the vendor in the most efficient and reasonable way possible; and

(3) monitor and evaluate the cost and effectiveness of the services.

**EFFECTIVE DATE.** This section is effective January 1, 2021.

Sec. 28. Minnesota Statutes 2018, section 252.45, is amended to read:

**252.45 VENDOR'S DUTIES.**

A day service vendor enrolled with the commissioner is responsible for items under clauses (1), (2), and (3), and extends only to the provision of services that are reimbursable under state and federal law. A vendor providing day ~~training and habilitation~~ services shall:

(1) provide the amount and type of services authorized in the individual service plan under coordinated service and support plan and coordinated service and support plan addendum required under sections 245D.02, subdivision 4, paragraphs (b) and (c), and 256B.092, subdivision 1b, and Minnesota Rules, ~~parts~~ part 9525.0004 ~~to 9525.0036~~, subpart 12;

(2) design the services to achieve the outcomes assigned to the vendor in the ~~individual service plan~~ coordinated service and support plan and coordinated service and support plan addendum required under sections 245D.02, subdivision 4, paragraphs (a) and (b), and 256B.092, subdivision 1b, and Minnesota Rules, part 9525.0004, subpart 12;

(3) provide or arrange for transportation of persons receiving services to and from service sites;

(4) enter into agreements with community-based intermediate care facilities for persons with developmental disabilities to ensure compliance with applicable federal regulations; and

(5) comply with state and federal law.

**EFFECTIVE DATE.** This section is effective January 1, 2021.

Sec. 29. Minnesota Statutes 2018, section 256.9365, is amended to read:

**256.9365 PURCHASE OF ~~CONTINUATION~~ HEALTH CARE COVERAGE FOR ~~AIDS PATIENTS~~ PEOPLE LIVING WITH HIV.**

Subdivision 1. **Program established.** The commissioner of human services shall establish a program to pay ~~private~~ the cost of health plan premiums and cost sharing for prescriptions, including co-payments, deductibles, and coinsurance for persons who have contracted human immunodeficiency virus (HIV) to enable them to continue coverage under or enroll in a group or individual health plan. If a person is determined to be eligible under subdivision 2, the commissioner shall pay the ~~portion of the group plan premium for which the individual is responsible, if the individual is responsible for at least 50 percent of the cost of the premium, or pay the individual plan premium~~ health insurance premiums and prescription cost sharing, including co-payments and deductibles required under section 256B.0631. The commissioner shall not pay for that portion of a premium that is attributable to other family members or dependents or is paid by the individual's employer.

Subd. 2. **Eligibility requirements.** To be eligible for the program, an applicant must ~~satisfy the following requirements:~~ meet all eligibility requirements for Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009, Public Law 111-87, and enroll in the Minnesota Ryan White program.

~~(1) the applicant must provide a physician's, advanced practice registered nurse's, or physician assistant's statement verifying that the applicant is infected with HIV and is, or within three months is likely to become, too ill to work in the applicant's current employment because of HIV-related disease;~~

~~(2) the applicant's monthly gross family income must not exceed 300 percent of the federal poverty guidelines, after deducting medical expenses and insurance premiums;~~

~~(3) the applicant must not own assets with a combined value of more than $25,000; and~~

~~(4) if applying for payment of group plan premiums, the applicant must be covered by an employer's or former employer's group insurance plan.~~

Subd. 3. **Cost-effective coverage.** Requirements for the payment of individual plan premiums under subdivision 2~~, clause (5),~~ must be designed to ensure that the state cost of paying an individual plan premium does not exceed the estimated state cost that would otherwise be incurred in the medical assistance program. The commissioner shall purchase the most cost-effective coverage available for eligible individuals.

Sec. 30. Minnesota Statutes 2018, section 256B.0658, is amended to read:

**256B.0658 HOUSING ACCESS GRANTS.**

The commissioner of human services shall award through a competitive process contracts for grants to public and private agencies to support and assist individuals ~~eligible for publicly funded home and community-based services, including state plan home care~~ with a disability as defined in section 256B.051, subdivision 2, paragraph (e), to access housing. Grants may be awarded to agencies that may include, but are not limited to, the following supports: assessment to ensure suitability of housing, accompanying an individual to look at housing, filling out applications and rental agreements, meeting with landlords, helping with Section 8 or other program applications, helping to develop a budget, obtaining furniture and household goods, if necessary, and assisting with any problems that may arise with housing.

Sec. 31. Minnesota Statutes 2018, section 256B.0659, subdivision 11, is amended to read:

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study. Except as provided in subdivision 11a, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

(i) not disqualified under section 245C.14; or

(ii) is disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional or physician;

(6) not be a consumer of personal care assistance services;

(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient; and

(10) be limited to providing and being paid for up to 275 hours per month of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with. The number of hours worked per day shall not be disallowed by the department unless in violation of the law.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Persons who do not qualify as a personal care assistant include parents, stepparents, and legal guardians of minors; spouses; paid legal guardians of adults; family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a; and staff of a residential setting.

(d) Personal care assistance services qualify for the enhanced rate described in subdivision 17a if the personal care assistant providing the services:

(1) provides services, according to the care plan in subdivision 7, to a recipient who qualifies for 12 or more hours per day of personal care assistance services; and

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in the Code

of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved training or competency requirements.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 32. Minnesota Statutes 2018, section 256B.0659, is amended by adding a subdivision to read:

Subd. 17a. **Enhanced rate.** An enhanced rate of 107.5 percent of the rate paid for personal care assistance services shall be paid for services provided to persons who qualify for 12 or more hours of personal care assistance services per day when provided by a personal care assistant who meets the requirements of subdivision 11, paragraph (d). The enhanced rate for personal care assistance services includes, and is not in addition to, any rate adjustments implemented by the commissioner on July 1, 2019, to comply with the terms of a collective bargaining agreement between the state of Minnesota and an exclusive representative of individual providers under section 179A.54, that provides for wage increases for individual providers who serve participants assessed to need 12 or more hours of personal care assistance services per day.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 33. Minnesota Statutes 2018, section 256B.0659, subdivision 21, is amended to read:

Subd. 21. **Requirements for provider enrollment of personal care assistance provider agencies.** (a) All personal care assistance provider agencies must provide, at the time of enrollment, reenrollment, and revalidation as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the personal care assistance provider agency's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage. Upon new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If the Medicaid revenue in the previous year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(3) proof of fidelity bond coverage in the amount of $20,000;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a description of the personal care assistance provider agency's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;

(7) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(8) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

(9) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

(10) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section;

(11) documentation of the agency's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

(13) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers, except for other personal care assistance providers, all of the revenue generated by a medical assistance rate increase due to a collective bargaining agreement under section

179A.54 must be used for employee personal care assistant wages and benefits. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

(14) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from

the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

Sec. 34. Minnesota Statutes 2018, section 256B.0659, subdivision 24, is amended to read:

Subd. 24. **Personal care assistance provider agency; general duties.** A personal care assistance provider agency shall:

(1) enroll as a Medicaid provider meeting all provider standards, including completion of the required provider training;

(2) comply with general medical assistance coverage requirements;

(3) demonstrate compliance with law and policies of the personal care assistance program to be determined by the commissioner;

(4) comply with background study requirements;

(5) verify and keep records of hours worked by the personal care assistant and qualified professional;

(6) not engage in any agency-initiated direct contact or marketing in person, by phone, or other electronic means to potential recipients, guardians, or family members;

(7) pay the personal care assistant and qualified professional based on actual hours of services provided;

(8) withhold and pay all applicable federal and state taxes;

(9) effective January 1, 2010, document that the agency uses a minimum of 72.5 percent of the revenue generated by the medical assistance rate for personal care assistance services for employee personal care assistant wages and benefits. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation;

(10) make the arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

(11) enter into a written agreement under subdivision 20 before services are provided;

(12) report suspected neglect and abuse to the common entry point according to section 256B.0651;

(13) provide the recipient with a copy of the home care bill of rights at start of service; ~~and~~

(14) request reassessments at least 60 days prior to the end of the current authorization for personal care assistance services, on forms provided by the commissioner.; and

(15) document that the additional revenue the agency receives for the enhanced rate is passed on, in wages and benefits, to the personal care assistant who provided services to a recipient who is eligible for the enhanced rate.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 35. Minnesota Statutes 2018, section 256B.0659, subdivision 28, is amended to read:

Subd. 28. **Personal care assistance provider agency; required documentation.** (a) Required documentation must be completed and kept in the personal care assistance provider agency file or the recipient's home residence. The required documentation consists of:

(1) employee files, including:

(i) applications for employment;

(ii) background study requests and results;

(iii) orientation records about the agency policies;

(iv) trainings completed with demonstration of competence, including verification of the completion of training required under subdivision 11, paragraph (d), if personal care assistance services eligible for the enhanced rate are provided and submitted for reimbursement under this section;

(v) supervisory visits;

(vi) evaluations of employment; and

(vii) signature on fraud statement;

(2) recipient files, including:

(i) demographics;

(ii) emergency contact information and emergency backup plan;

(iii) personal care assistance service plan;

(iv) personal care assistance care plan;

(v) month-to-month service use plan;

(vi) all communication records;

(vii) start of service information, including the written agreement with recipient; and

(viii) date the home care bill of rights was given to the recipient;

(3) agency policy manual, including:

(i) policies for employment and termination;

(ii) grievance policies with resolution of consumer grievances;

(iii) staff and consumer safety;

(iv) staff misconduct; and

(v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and resolution of consumer grievances;

(4) time sheets for each personal care assistant along with completed activity sheets for each recipient served; and

(5) agency marketing and advertising materials and documentation of marketing activities and costs.

(b) The commissioner may assess a fine of up to $500 on provider agencies that do not consistently comply with the requirements of this subdivision.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 36. **[256B.0715] DIRECT CARE WORKFORCE REPORT.**

The commissioner of human services shall annually assess the direct care workforce and publish findings in a direct care workforce report each August beginning August 1, 2020. This report shall consider the number of workers employed, the number of regular hours worked, the number of overtime hours worked, the regular wages and benefits paid, the overtime wages paid, retention rates, and job vacancies across providers of home and community-based services disability waiver services, state plan home care services, state plan personal care assistance services, and community first services and supports.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 37. Minnesota Statutes 2018, section 256B.0915, subdivision 3a, is amended to read:

Subd. 3a. **Elderly waiver cost limits.** (a) Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256R.17 for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waivered services to an individual elderly waiver client shall be the monthly limit of the case mix resident class to which the waiver client

would be assigned under Minnesota Rules, parts 9549.0051 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by any legislatively adopted home and community-based services percentage rate adjustment. If a legislatively authorized increase is service-specific, the monthly cost limit shall be adjusted based on the overall average increase to the elderly waiver program.

(b) The monthly limit for the cost of waivered services under paragraph (a) to an individual elderly waiver client assigned to a case mix classification A with:

(1) no dependencies in activities of daily living; or

(2) up to two dependencies in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911 shall be $1,750 per month effective on July 1, 2011, for all new participants enrolled in the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in paragraphs (a) and (e).

(c) If extended medical supplies and equipment or environmental modifications are or will be purchased for an elderly waiver client, the costs may be prorated for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's waivered services exceeds the monthly limit established in paragraph (a), (b), (d), or (e), the annual cost of all waivered services shall be determined. In this event, the annual cost of all waivered services shall not exceed 12 times the monthly limit of waivered services as described in paragraph (a), (b), (d), or (e).

(d) Effective July 1, 2013, the monthly cost limit of waiver services, including any necessary home care services described in section 256B.0651, subdivision 2, for individuals who meet the criteria as ventilator-dependent given in section 256B.0651, subdivision 1, paragraph (g), shall be the average of the monthly medical assistance amount established for home care services as described in section 256B.0652, subdivision 7, and the annual average contracted amount established by the commissioner for nursing facility services for ventilator-dependent individuals. This monthly limit shall be increased annually as described in paragraphs (a) and (e).

(e) Effective January 1, 2018, and each January 1 thereafter, the monthly cost limits for elderly waiver services in effect on the previous December 31 shall be increased by the difference between any legislatively adopted home and community-based provider rate increases effective on January 1 or since the previous January 1 and the average statewide percentage increase in nursing facility operating payment rates under chapter 256R, effective

the previous January 1. This paragraph shall only apply if the average statewide percentage increase in nursing facility operating payment rates is greater than any legislatively adopted home and community-based provider rate increases effective on January 1, or occurring since the previous January 1.

(f) The commissioner shall approve an exception to the monthly case mix budget cap in paragraph (a) to account for the additional cost of providing enhanced rate personal care assistance services under section 256B.0659 or 256B.85. The exception shall not exceed 107.5 percent of the budget otherwise available to the individual. The exception must be reapproved on an annual basis at the time of a participant's annual reassessment.

**EFFECTIVE DATE.** This section is effective July 1, 2019, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 38. Minnesota Statutes 2018, section 256B.0949, is amended by adding a subdivision to read:

Subd. 16a. **Background studies.** The requirements for background studies under this section shall be met by an early intensive developmental and behavioral intervention services agency through the commissioner's NETStudy system as provided under sections 245C.03, subdivision 13, and 245C.10, subdivision 14.

Sec. 39. Minnesota Statutes 2018, section 256B.4913, subdivision 4a, is amended to read:

Subd. 4a. **Rate stabilization adjustment.** (a) For purposes of this subdivision, "implementation period" means the period beginning January 1, 2014, and ending on the last day of the month in which the rate management system is populated with the data necessary to calculate rates for substantially all individuals receiving home and community-based waiver services under sections 256B.092 and 256B.49. "Banding period" means the time period beginning on January 1, 2014, and ending upon the expiration of the 12-month period defined in paragraph (c), clause (5).

(b) For purposes of this subdivision, the historical rate for all service recipients means the individual reimbursement rate for a recipient in effect on December 1, 2013, except that:

(1) for a day service recipient who was not authorized to receive these waiver services prior to January 1, 2014; added a new service or services on or after January 1, 2014; or changed providers on or after January 1, 2014, the historical rate must be the weighted

average authorized rate for the provider number in the county of service, effective December 1, 2013; or

(2) for a unit-based service with programming or a unit-based service without programming recipient who was not authorized to receive these waiver services prior to January 1, 2014; added a new service or services on or after January 1, 2014; or changed providers on or after January 1, 2014, the historical rate must be the weighted average authorized rate for each provider number in the county of service, effective December 1, 2013; or

(3) for residential service recipients who change providers on or after January 1, 2014, the historical rate must be set by each lead agency within their county aggregate budget using their respective methodology for residential services effective December 1, 2013, for determining the provider rate for a similarly situated recipient being served by that provider.

(c) The commissioner shall adjust individual reimbursement rates determined under this section so that the unit rate is no higher or lower than:

(1) 0.5 percent from the historical rate for the implementation period;

(2) 0.5 percent from the rate in effect in clause (1), for the 12-month period immediately following the time period of clause (1);

(3) 0.5 percent from the rate in effect in clause (2), for the 12-month period immediately following the time period of clause (2);

(4) 1.0 percent from the rate in effect in clause (3), for the 12-month period immediately following the time period of clause (3);

(5) 1.0 percent from the rate in effect in clause (4), for the 12-month period immediately following the time period of clause (4); and

(6) no adjustment to the rate in effect in clause (5) for the 12-month period immediately following the time period of clause (5). During this banding rate period, the commissioner shall not enforce any rate decrease or increase that would otherwise result from the end of the banding period. ~~The commissioner shall, upon enactment, seek federal approval for the addition of this banding period; and~~

~~(7) one percent from the rate in effect in clause (6) for the 12-month period immediately following the time period of clause (6).~~

(d) The commissioner shall review all changes to rates that were in effect on December 1, 2013, to verify that the rates in effect produce the equivalent level of spending and service unit utilization on an annual basis as those in effect on October 31, 2013.

(e) By December 31, 2014, the commissioner shall complete the review in paragraph (d), adjust rates to provide equivalent annual spending, and make appropriate adjustments.

(f) During the banding period, the Medicaid Management Information System (MMIS) service agreement rate must be adjusted to account for change in an individual's need. The commissioner shall adjust the Medicaid Management Information System (MMIS) service agreement rate by:

(1) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the individual with variables reflecting the level of service in effect on December 1, 2013;

(2) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the individual with variables reflecting the updated level of service at the time of application; and

(3) adding to or subtracting from the Medicaid Management Information System (MMIS) service agreement rate, the difference between the values in clauses (1) and (2).

(g) This subdivision must not apply to rates for recipients served by providers new to a given county after January 1, 2014. Providers of personal supports services who also acted as fiscal support entities must be treated as new providers as of January 1, 2014.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 40. Minnesota Statutes 2018, section 256B.4913, subdivision 5, is amended to read:

Subd. 5. **Stakeholder consultation and county training.** (a) The commissioner shall continue consultation on regular intervals with the existing stakeholder group established as part of the rate-setting methodology process and others, to gather input, concerns, and data, to assist in the ~~full implementation~~ ongoing administration of the ~~new~~ rate payment system and to make pertinent information available to the public through the department's website.

(b) The commissioner shall offer training at least annually for county personnel responsible for administering the rate-setting framework in a manner consistent with this section and section 256B.4914.

(c) The commissioner shall maintain an online instruction manual explaining the rate-setting framework. The manual shall be consistent with this section and section

256B.4914, and shall be accessible to all stakeholders including recipients, representatives of recipients, county or tribal agencies, and license holders.

(d) The commissioner shall not defer to the county or tribal agency on matters of technical application of the rate-setting framework, and a county or tribal agency shall not set rates in a manner that conflicts with this section or section 256B.4914.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 41. Minnesota Statutes 2018, section 256B.4914, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them, unless the context clearly indicates otherwise.

(b) "Commissioner" means the commissioner of human services.

(c) "Comparable occupations" means the occupations, excluding direct care staff, as represented by the Bureau of Labor Statistics standard occupational classification codes that have the same classification for:

(1) typical education needed for entry;

(2) work experience in a related occupation; and

(3) typical on-the-job training competency as the most predominant classification for direct care staff.

~~(c)~~ (d) "Component value" means underlying factors that are part of the cost of providing services that are built into the waiver rates methodology to calculate service rates.

~~(d)~~ (e) "Customized living tool" means a methodology for setting service rates that delineates and documents the amount of each component service included in a recipient's customized living service plan.

(f) "Direct care staff" means employees providing direct service to people receiving services under this section. Direct care staff excludes executive, managerial, and administrative staff.

~~(e)~~ (g) "Disability waiver rates system" means a statewide system that establishes rates that are based on uniform processes and captures the individualized nature of waiver services and recipient needs.

~~(f)~~ (h) "Individual staffing" means the time spent as a one-to-one interaction specific to an individual recipient by staff to provide direct support and assistance with activities of daily living, instrumental activities of daily living, and training to participants, and is based

on the requirements in each individual's coordinated service and support plan under section 245D.02, subdivision 4b; any coordinated service and support plan addendum under section 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's needs must also be considered.

~~(g)~~ (i) "Lead agency" means a county, partnership of counties, or tribal agency charged with administering waivered services under sections 256B.092 and 256B.49.

~~(h)~~ (j) "Median" means the amount that divides distribution into two equal groups, one-half above the median and one-half below the median.

~~(i)~~ (k) "Payment or rate" means reimbursement to an eligible provider for services provided to a qualified individual based on an approved service authorization.

~~(j)~~ (l) "Rates management system" means a web-based software application that uses a framework and component values, as determined by the commissioner, to establish service rates.

~~(k)~~ (m) "Recipient" means a person receiving home and community-based services funded under any of the disability waivers.

~~(l)~~ (n) "Shared staffing" means time spent by employees, not defined under paragraph (f), providing or available to provide more than one individual with direct support and assistance with activities of daily living as defined under section 256B.0659, subdivision 1, paragraph (b); instrumental activities of daily living as defined under section 256B.0659, subdivision 1, paragraph (i); ancillary activities needed to support individual services; and training to participants, and is based on the requirements in each individual's coordinated service and support plan under section 245D.02, subdivision 4b; any coordinated service and support plan addendum under section 245D.02, subdivision 4c; an assessment tool; and provider observation of an individual's service need. Total shared staffing hours are divided proportionally by the number of individuals who receive the shared service provisions.

~~(m)~~ (o) "Staffing ratio" means the number of recipients a service provider employee supports during a unit of service based on a uniform assessment tool, provider observation, case history, and the recipient's services of choice, and not based on the staffing ratios under section 245D.31.

~~(n)~~ (p) "Unit of service" means the following:

(1) for residential support services under subdivision 6, a unit of service is a day. Any portion of any calendar day, within allowable Medicaid rules, where an individual spends time in a residential setting is billable as a day;

(2) for day services under subdivision 7:

(i) for day training and habilitation services, a unit of service is either:

(A) a day unit of service is defined as six or more hours of time spent providing direct services and transportation; or

(B) a partial day unit of service is defined as fewer than six hours of time spent providing direct services and transportation; and

(C) for new day service recipients after January 1, 2014, 15 minute units of service must be used for fewer than six hours of time spent providing direct services and transportation;

(ii) for adult day and structured day services, a unit of service is a day or 15 minutes. A day unit of service is six or more hours of time spent providing direct services;

(iii) for day support services, a unit of service is 15 minutes; and

~~(iii)~~ (iv) for prevocational services, a unit of service is a day or an hour. A day unit of service is six or more hours of time spent providing direct service;

(3) for unit-based services with programming under subdivision 8:

(i) for supported living services, a unit of service is a day or 15 minutes. When a day rate is authorized, any portion of a calendar day where an individual receives services is billable as a day; and

(ii) for all other services, a unit of service is 15 minutes; and

(4) for unit-based services without programming under subdivision 9, a unit of service is 15 minutes.

Sec. 42. Minnesota Statutes 2018, section 256B.4914, subdivision 4, is amended to read:

Subd. 4. **Data collection for rate determination.** (a) Rates for applicable home and community-based waivered services, including rate exceptions under subdivision 12, are set by the rates management system.

~~(b) Data for services under section 256B.4913, subdivision 4a, shall be collected in a manner prescribed by the commissioner.~~

~~(c)~~ (b) Data and information in the rates management system may be used to calculate an individual's rate.

~~(d)~~ (c) Service providers, with information from the community support plan and oversight by lead agencies, shall provide values and information needed to calculate an

individual's rate into the rates management system. The determination of service levels must be part of a discussion with members of the support team as defined in section 245D.02, subdivision 34. This discussion must occur prior to the final establishment of each individual's rate. The values and information include:

(1) shared staffing hours;

(2) individual staffing hours;

(3) direct registered nurse hours;

(4) direct licensed practical nurse hours;

(5) staffing ratios;

(6) information to document variable levels of service qualification for variable levels of reimbursement in each framework;

(7) shared or individualized arrangements for unit-based services, including the staffing ratio;

(8) number of trips and miles for transportation services; and

(9) service hours provided through monitoring technology.

~~(e)~~ (d) Updates to individual data must include:

(1) data for each individual that is updated annually when renewing service plans; and

(2) requests by individuals or lead agencies to update a rate whenever there is a change in an individual's service needs, with accompanying documentation.

~~(f)~~ (e) Lead agencies shall review and approve all services reflecting each individual's needs, and the values to calculate the final payment rate for services with variables under subdivisions 6, 7, 8, and 9 for each individual. Lead agencies must notify the individual and the service provider of the final agreed-upon values and rate, and provide information that is identical to what was entered into the rates management system. If a value used was mistakenly or erroneously entered and used to calculate a rate, a provider may petition lead agencies to correct it. Lead agencies must respond to these requests. When responding to the request, the lead agency must consider:

(1) meeting the health and welfare needs of the individual or individuals receiving services by service site, identified in their coordinated service and support plan under section 245D.02, subdivision 4b, and any addendum under section 245D.02, subdivision 4c;

(2) meeting the requirements for staffing under subdivision 2, paragraphs ~~(f)~~ (h), ~~(i)~~ (n), and ~~(m)~~ (o); and meeting or exceeding the licensing standards for staffing required under section 245D.09, subdivision 1; and

(3) meeting the staffing ratio requirements under subdivision 2, paragraph ~~(n)~~ (o), and meeting or exceeding the licensing standards for staffing required under section 245D.31.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 43. Minnesota Statutes 2018, section 256B.4914, subdivision 5, is amended to read:

Subd. 5. **Base wage index and standard component values.** (a) The base wage index is established to determine staffing costs associated with providing services to individuals receiving home and community-based services. For purposes of developing and calculating the proposed base wage, Minnesota-specific wages taken from job descriptions and standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in the most recent edition of the Occupational Handbook must be used. The base wage index must be calculated as follows:

(1) for residential direct care staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for personal and home health aide (SOC code 39-9021); 30 percent of the median wage for nursing assistant (SOC code 31-1014); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(2) for day services, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(3) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota for large employers, except in a family foster care setting, the wage is 36 percent of the minimum wage in Minnesota for large employers;

(4) for behavior program analyst staff, 100 percent of the median wage for mental health counselors (SOC code 21-1014);

(5) for behavior program professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(6) for behavior program specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

(7) for supportive living services staff, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(8) for housing access coordination staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099);

(9) for in-home family support staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30 percent of the median wage for community social service specialist (SOC code 21-1099); 40 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(10) for individualized home supports services staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(11) for independent living skills staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(12) for independent living skills specialist staff, 100 percent of mental health and substance abuse social worker (SOC code 21-1023);

(13) for supported employment staff, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(14) for employment support services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(15) for employment exploration services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(16) for employment development services staff, 50 percent of the median wage for education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(17) for adult companion staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(18) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(19) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(20) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(21) for supervisory staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099), with the exception of the supervisor of behavior professional, behavior analyst, and behavior specialists, which is 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(22) for registered nurse staff, 100 percent of the median wage for registered nurses (SOC code 29-1141); and

(23) for licensed practical nurse staff, 100 percent of the median wage for licensed practical nurses (SOC code 29-2061).

(b) Component values for residential support services are:

(1) competitive workforce factor: 4.7 percent;

~~(1)~~ (2) supervisory span of control ratio: 11 percent;

~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

~~(3)~~ (4) employee-related cost ratio: 23.6 percent;

~~(4)~~ (5) general administrative support ratio: 13.25 percent;

~~(5)~~ (6) program-related expense ratio: 1.3 percent; and

~~(6)~~ (7) absence and utilization factor ratio: 3.9 percent.

(c) Component values for family foster care are:

(1) competitive workforce factor: 4.7 percent;

~~(1)~~ (2) supervisory span of control ratio: 11 percent;

~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

~~(3)~~ (4) employee-related cost ratio: 23.6 percent;

~~(4)~~ (5) general administrative support ratio: 3.3 percent;

~~(5)~~ (6) program-related expense ratio: 1.3 percent; and

~~(6)~~ (7) absence factor: 1.7 percent.

(d) Component values for day services for all services are:

(1) competitive workforce factor: 4.7 percent;

~~(1)~~ (2) supervisory span of control ratio: 11 percent;

~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

~~(3)~~ (4) employee-related cost ratio: 23.6 percent;

~~(4)~~ (5) program plan support ratio: 5.6 percent;

~~(5)~~ (6) client programming and support ratio: ten percent;

~~(6)~~ (7) general administrative support ratio: 13.25 percent;

~~(7)~~ (8) program-related expense ratio: 1.8 percent; and

~~(8)~~ (9) absence and utilization factor ratio: 9.4 percent.

(e) Component values for unit-based services with programming are:

(1) competitive workforce factor: 4.7 percent;

~~(1)~~ (2) supervisory span of control ratio: 11 percent;

~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

~~(3)~~ (4) employee-related cost ratio: 23.6 percent;

~~(4)~~ (5) program plan supports ratio: 15.5 percent;

~~(5)~~ (6) client programming and supports ratio: 4.7 percent;

~~(6)~~ (7) general administrative support ratio: 13.25 percent;

~~(7)~~ (8) program-related expense ratio: 6.1 percent; and

~~(8)~~ (9) absence and utilization factor ratio: 3.9 percent.

(f) Component values for unit-based services without programming except respite are:

(1) competitive workforce factor: 4.7 percent;

~~(1)~~ (2) supervisory span of control ratio: 11 percent;

~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

~~(3)~~ (4) employee-related cost ratio: 23.6 percent;

~~(4)~~ (5) program plan support ratio: 7.0 percent;

~~(5)~~ (6) client programming and support ratio: 2.3 percent;

~~(6)~~ (7) general administrative support ratio: 13.25 percent;

~~(7)~~ (8) program-related expense ratio: 2.9 percent; and

~~(8)~~ (9) absence and utilization factor ratio: 3.9 percent.

(g) Component values for unit-based services without programming for respite are:

(1) competitive workforce factor: 4.7 percent;

~~(1)~~ (2) supervisory span of control ratio: 11 percent;

~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

~~(3)~~ (4) employee-related cost ratio: 23.6 percent;

~~(4)~~ (5) general administrative support ratio: 13.25 percent;

~~(5)~~ (6) program-related expense ratio: 2.9 percent; and

~~(6)~~ (7) absence and utilization factor ratio: 3.9 percent.

(h) ~~On July 1, 2017, the commissioner shall update the base wage index in paragraph (a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor Statistics available on December 31, 2016. The commissioner shall publish these updated values and load them into the rate management system.~~ On July 1, 2022, and every ~~five~~ two years thereafter, the commissioner shall update the base wage index in paragraph (a) based

on the most recently available wage data by SOC from the Bureau of Labor Statistics. The commissioner shall publish these updated values and load them into the rate management system.

(i) On July 1, 2022, and July 1, 2024, the commissioner shall increase paragraph (b), clause (1); paragraph (c), clause (1); paragraph (d), clause (1); paragraph (e), clause (1); paragraph (f), clause (1); and paragraph (g), clause (1), by two percentage points.

(j) Beginning January 1, 2026, the commissioner shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance an analysis of the competitive workforce factor. The report must include recommendations to update the competitive workforce factor using:

(1) the most recently available wage data by SOC code for the weighted average wage for direct care staff for residential services and direct care staff for day services;

(2) the most recently available wage data by SOC code of the weighted average wage of comparable occupations; and

(3) workforce data as required under subdivision 10a, paragraph (g).

The commissioner shall not recommend an increase or decrease of the competitive workforce factor from the current value by more than two percentage points. If, after a biennial analysis for the next report, the competitive workforce factor is less than or equal to zero, the commissioner shall recommend a competitive workforce factor of zero.

~~(i) On July 1, 2017, the commissioner shall update the framework components in paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner will adjust these values higher or lower by the percentage change in the Consumer Price Index-All Items, United States city average (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these updated values and load them into the rate management system.~~ (k) On July 1, 2022, and every ~~five~~ two years thereafter, the commissioner shall update the framework components in paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner shall adjust these values higher or lower by the percentage change in the CPI-U from the date of the previous update to the ~~date of the~~ data most recently available prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

(l) Upon the implementation of the updates under paragraphs (h) and (k), rate adjustments authorized under section 256B.439, subdivision 7; Laws 2013, chapter 108, article 7, section 60; and Laws 2014, chapter 312, article 27, section 75, shall be removed from service rates calculated under this section.

(m) Any rate adjustments applied to the service rates calculated under this section outside of the cost components and rate methodology specified in this section shall be removed from rate calculations upon implementation of the updates under paragraphs (h) and (k).

~~(j)~~ (n) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer Price Index items are unavailable in the future, the commissioner shall recommend to the legislature codes or items to update and replace missing component values.

**EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval, except:

(1) paragraphs (h) and (k) are effective July 1, 2022, or upon federal approval, whichever is later; and

(2) paragraph (l) is effective retroactively from July 1, 2018.

The commissioner of human services shall notify the revisor of statutes when federal approval is obtained or denied.

Sec. 44. Minnesota Statutes 2018, section 256B.4914, is amended by adding a subdivision to read:

Subd. 5a. **Direct care staff; compensation.** (a) A provider paid with rates determined under subdivision 6 must use a minimum of 66 percent of the revenue generated by rates determined under subdivision 6 for direct care staff compensation.

(b) A provider paid with rates determined under subdivision 7 must use a minimum of 45 percent of the revenue generated by rates determined under subdivision 7 for direct care staff compensation.

(c) A provider paid with rates determined under subdivision 8 or 9 must use a minimum of 55 percent of the revenue generated by rates determined under subdivisions 8 and 9 for direct care staff compensation.

(d) Applicable compensation under this subdivision includes:

(1) wages;

(2) Social Security and Medicare taxes;

(3) federal unemployment insurance tax;

(4) state unemployment insurance tax;

(5) workers' compensation insurance;

(6) health insurance;

(7) dental insurance;

(8) vision insurance;

(9) life insurance;

(10) short-term disability insurance;

(11) long-term disability insurance;

(12) retirement spending;

(13) tuition reimbursement;

(14) wellness programs;

(15) paid vacation time;

(16) paid sick time; or

(17) other items of monetary value provided to direct care staff.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 45. Minnesota Statutes 2018, section 256B.4914, subdivision 6, is amended to read:

Subd. 6. **Payments for residential support services.** (a) Payments for residential support services, as defined in sections 256B.092, subdivision 11, and 256B.49, subdivision 22, must be calculated as follows:

(1) determine the number of shared staffing and individual direct staff hours to meet a recipient's needs provided on site or through monitoring technology;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5~~. This is defined as the direct-care rate~~;

(3) except for subdivision 5, paragraph (a), clauses (3) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (b), clause (1);

~~(3)~~ (4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause ~~(2)~~ (3)~~. This is defined as the customized direct-care rate~~;

~~(4)~~ (5) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the appropriate staff wages ~~in subdivision 5, paragraph (a), or the customized direct-care rate~~;

~~(5)~~ (6) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the product of the supervision span of control ratio in subdivision 5, paragraph (b), clause ~~(1)~~ (2), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

~~(6)~~ (7) combine the results of clauses ~~(4) and~~ (5) and (6), excluding any shared and individual direct staff hours provided through monitoring technology, and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause ~~(2)~~ (3). This is defined as the direct staffing cost;

~~(7)~~ (8) for employee-related expenses, multiply the direct staffing cost, excluding any shared and individual direct staff hours provided through monitoring technology, by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause ~~(3)~~ (4);

~~(8)~~ (9) for client programming and supports, the commissioner shall add $2,179; and

~~(9)~~ (10) for transportation, if provided, the commissioner shall add $1,680, or $3,000 if customized for adapted transport, based on the resident with the highest assessed need.

(b) The total rate must be calculated using the following steps:

(1) subtotal paragraph (a), clauses ~~(7) to (9)~~ (8) to (10), and the direct staffing cost of any shared and individual direct staff hours provided through monitoring technology that was excluded in clause ~~(7)~~ (8);

(2) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization ratio;

(3) divide the result of clause (1) by one minus the result of clause (2). This is the total payment amount; and

(4) adjust the result of clause (3) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(c) The payment methodology for customized living, 24-hour customized living, and residential care services must be the customized living tool. Revisions to the customized

living tool must be made to reflect the services and activities unique to disability-related recipient needs.

~~(d) For individuals enrolled prior to January 1, 2014, the days of service authorized must meet or exceed the days of service used to convert service agreements in effect on December 1, 2013, and must not result in a reduction in spending or service utilization due to conversion during the implementation period under section 256B.4913, subdivision 4a. If during the implementation period, an individual's historical rate, including adjustments required under section 256B.4913, subdivision 4a, paragraph (e), is equal to or greater than the rate determined in this subdivision, the number of days authorized for the individual is 365.~~

~~(e)~~ (d) The number of days authorized for all individuals enrolling ~~after January 1, 2014,~~ in residential services must include every day that services start and end.

**EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 46. Minnesota Statutes 2018, section 256B.4914, subdivision 7, is amended to read:

Subd. 7. **Payments for day programs.** Payments for services with day programs including adult day ~~care~~ services, day treatment and habilitation, day support services, prevocational services, and structured day services must be calculated as follows:

(1) determine the number of units of service and staffing ratio to meet a recipient's needs:

(i) the staffing ratios for the units of service provided to a recipient in a typical week must be averaged to determine an individual's staffing ratio; and

(ii) the commissioner, in consultation with service providers, shall develop a uniform staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) except for subdivision 5, paragraph (a), clauses (3) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (d), clause (1);

~~(3)~~ (4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause ~~(2)~~ (3)~~. This is defined as the customized direct-care rate~~;

~~(4)~~ (5) multiply the number of day program direct staff hours and nursing hours by the appropriate staff wage ~~in subdivision 5, paragraph (a), or the customized direct-care rate~~;

~~(5)~~ (6) multiply the number of day direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (d), clause ~~(1)~~ (2), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

~~(6)~~ (7) combine the results of clauses ~~(4) and~~ (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d), clause ~~(2)~~ (3). This is defined as the direct staffing rate;

~~(7)~~ (8) for program plan support, multiply the result of clause ~~(6)~~ (7) by one plus the program plan support ratio in subdivision 5, paragraph (d), clause ~~(4)~~ (5);

~~(8)~~ (9) for employee-related expenses, multiply the result of clause ~~(7)~~ (8) by one plus the employee-related cost ratio in subdivision 5, paragraph (d), clause ~~(3)~~ (4);

~~(9)~~ (10) for client programming and supports, multiply the result of clause ~~(8)~~ (9) by one plus the client programming and support ratio in subdivision 5, paragraph (d), clause ~~(5)~~ (6);

~~(10)~~ (11) for program facility costs, add $19.30 per week with consideration of staffing ratios to meet individual needs;

~~(11)~~ (12) for adult day bath services, add $7.01 per 15 minute unit;

~~(12)~~ (13) this is the subtotal rate;

~~(13)~~ (14) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

~~(14)~~ (15) divide the result of clause ~~(12)~~ (13) by one minus the result of clause ~~(13)~~ (14). This is the total payment amount;

~~(15)~~ (16) adjust the result of clause ~~(14)~~ (15) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services;

~~(16)~~ (17) for transportation provided as part of day training and habilitation for an individual who does not require a lift, add:

(i) $10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without a lift, $8.83 for a shared ride in a vehicle without a lift, and $9.25 for a shared ride in a vehicle with a lift;

(ii) $15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without a lift, $10.58 for a shared ride in a vehicle without a lift, and $11.88 for a shared ride in a vehicle with a lift;

(iii) $25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without a lift, $13.92 for a shared ride in a vehicle without a lift, and $16.88 for a shared ride in a vehicle with a lift; or

(iv) $33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift, $16.50 for a shared ride in a vehicle without a lift, and $20.75 for a shared ride in a vehicle with a lift;

~~(17)~~ (18) for transportation provided as part of day training and habilitation for an individual who does require a lift, add:

(i) $19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a lift, and $15.05 for a shared ride in a vehicle with a lift;

(ii) $32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a lift, and $28.16 for a shared ride in a vehicle with a lift;

(iii) $58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a lift, and $58.76 for a shared ride in a vehicle with a lift; or

(iv) $80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift, and $80.93 for a shared ride in a vehicle with a lift.

**EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 47. Minnesota Statutes 2018, section 256B.4914, subdivision 8, is amended to read:

Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based services with programming, including ~~behavior programming~~ employment exploration services, employment development services, housing access coordination, individualized home supports with family training, individualized home supports with training, in-home family support, independent living skills training, ~~independent living skills specialist services, individualized home supports, hourly supported living services, employment exploration services, employment development services, supported employment, and employment support~~ and hourly supported living services provided to an individual outside of any day

or residential service plan must be calculated as follows, unless the services are authorized separately under subdivision 6 or 7:

(1) determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) except for subdivision 5, paragraph (a), clauses (3) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (e), clause (1);

~~(3)~~ (4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause ~~(2)~~ (3)~~. This is defined as the customized direct-care rate~~;

~~(4)~~ (5) multiply the number of direct staff hours by the appropriate staff wage ~~in subdivision 5, paragraph (a), or the customized direct-care rate~~;

~~(5)~~ (6) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (e), clause ~~(1)~~ (2), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

~~(6)~~ (7) combine the results of clauses ~~(4) and~~ (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (e), clause ~~(2)~~ (3). This is defined as the direct staffing rate;

~~(7)~~ (8) for program plan support, multiply the result of clause ~~(6)~~ (7) by one plus the program plan supports ratio in subdivision 5, paragraph (e), clause ~~(4)~~ (5);

~~(8)~~ (9) for employee-related expenses, multiply the result of clause ~~(7)~~ (8) by one plus the employee-related cost ratio in subdivision 5, paragraph (e), clause ~~(3)~~ (4);

~~(9)~~ (10) for client programming and supports, multiply the result of clause ~~(8)~~ (9) by one plus the client programming and supports ratio in subdivision 5, paragraph (e), clause ~~(5)~~ (6);

~~(10)~~ (11) this is the subtotal rate;

~~(11)~~ (12) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

~~(12)~~ (13) divide the result of clause ~~(10)~~ (11) by one minus the result of clause ~~(11)~~ (12). This is the total payment amount;

~~(13)~~ (14) for supported employment provided in a shared manner, divide the total payment amount in clause ~~(12)~~ (13) by the number of service recipients, not to exceed three. For employment support services provided in a shared manner, divide the total payment amount in clause ~~(12)~~ (13) by the number of service recipients, not to exceed six. For independent living skills training and individualized home supports provided in a shared manner, divide the total payment amount in clause ~~(12)~~ (13) by the number of service recipients, not to exceed two; and

~~(14)~~ (15) adjust the result of clause ~~(13)~~ (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

**EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 48. Minnesota Statutes 2018, section 256B.4914, subdivision 9, is amended to read:

Subd. 9. **Payments for unit-based services without programming.** Payments for unit-based services without programming, including night supervision, personal support, respite, and companion care provided to an individual outside of any day or residential service plan must be calculated as follows unless the services are authorized separately under subdivision 6 or 7:

(1) for all services except respite, determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(3) except for subdivision 5, paragraph (a), clauses (3) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (f), clause (1);

~~(3)~~ (4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause ~~(2)~~ (3)~~. This is defined as the customized direct care rate~~;

~~(4)~~ (5) multiply the number of direct staff hours by the appropriate staff wage ~~in subdivision 5 or the customized direct care rate~~;

~~(5)~~ (6) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (f), clause ~~(1)~~ (2), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

~~(6)~~ (7) combine the results of clauses ~~(4) and~~ (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (f), clause ~~(2)~~ (3). This is defined as the direct staffing rate;

~~(7)~~ (8) for program plan support, multiply the result of clause ~~(6)~~ (7) by one plus the program plan support ratio in subdivision 5, paragraph (f), clause ~~(4)~~ (5);

~~(8)~~ (9) for employee-related expenses, multiply the result of clause ~~(7)~~ (8) by one plus the employee-related cost ratio in subdivision 5, paragraph (f), clause ~~(3)~~ (4);

~~(9)~~ (10) for client programming and supports, multiply the result of clause ~~(8)~~ (9) by one plus the client programming and support ratio in subdivision 5, paragraph (f), clause ~~(5)~~ (6);

~~(10)~~ (11) this is the subtotal rate;

~~(11)~~ (12) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

~~(12)~~ (13) divide the result of clause ~~(10)~~ (11) by one minus the result of clause ~~(11)~~ (12). This is the total payment amount;

~~(13)~~ (14) for respite services, determine the number of day units of service to meet an individual's needs;

~~(14)~~ (15) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(16) except for subdivision 5, paragraph (a), clauses (3) and (21) to (23), multiply the result of clause (15) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (g), clause (1);

~~(15)~~ (17) for a recipient requiring deaf and hard-of-hearing customization under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause ~~(14)~~ (16)~~. This is defined as the customized direct care rate~~;

~~(16)~~ (18) multiply the number of direct staff hours by the appropriate staff wage ~~in subdivision 5, paragraph (a)~~;

~~(17)~~ (19) multiply the number of direct staff hours by the product of the supervisory span of control ratio in subdivision 5, paragraph (g), clause ~~(1)~~ (2), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

~~(18)~~ (20) combine the results of clauses ~~(16)~~ (18) and ~~(17)~~ (19), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (g), clause ~~(2)~~ (3). This is defined as the direct staffing rate;

~~(19)~~ (21) for employee-related expenses, multiply the result of clause ~~(18)~~ (20) by one plus the employee-related cost ratio in subdivision 5, paragraph (g), clause ~~(3)~~ (4);

~~(20)~~ (22) this is the subtotal rate;

~~(21)~~ (23) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

~~(22)~~ (24) divide the result of clause ~~(20)~~ (22) by one minus the result of clause ~~(21)~~ (23). This is the total payment amount; and

~~(23)~~ (25) adjust the result of clauses ~~(12)~~ (13) and ~~(22)~~ (24) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

**EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 49. Minnesota Statutes 2018, section 256B.4914, subdivision 10, is amended to read:

Subd. 10. **Updating payment values and additional information.** ~~(a) From January 1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform procedures to refine terms and adjust values used to calculate payment rates in this section.~~

~~(b)~~ (a) No later than July 1, 2014, the commissioner shall, within available resources, begin to conduct research and gather data and information from existing state systems or other outside sources on the following items:

(1) differences in the underlying cost to provide services and care across the state; and

(2) mileage, vehicle type, lift requirements, incidents of individual and shared rides, and units of transportation for all day services, which must be collected from providers using the rate management worksheet and entered into the rates management system; and

(3) the distinct underlying costs for services provided by a license holder under sections 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided by a license holder certified under section 245D.33.

~~(c) Beginning January 1, 2014, through December 31, 2018, using a statistically valid set of rates management system data, the commissioner, in consultation with stakeholders, shall analyze for each service the average difference in the rate on December 31, 2013, and the framework rate at the individual, provider, lead agency, and state levels. The commissioner shall issue semiannual reports to the stakeholders on the difference in rates by service and by county during the banding period under section 256B.4913, subdivision 4a. The commissioner shall issue the first report by October 1, 2014, and the final report shall be issued by December 31, 2018.~~

~~(d)~~ (b) No later than July 1, 2014, the commissioner, in consultation with stakeholders, shall begin the review and evaluation of the following values already in subdivisions 6 to 9, or issues that impact all services, including, but not limited to:

(1) values for transportation rates;

(2) values for services where monitoring technology replaces staff time;

(3) values for indirect services;

(4) values for nursing;

(5) values for the facility use rate in day services, and the weightings used in the day service ratios and adjustments to those weightings;

(6) values for workers' compensation as part of employee-related expenses;

(7) values for unemployment insurance as part of employee-related expenses;

(8) direct care workforce labor market measures;

(9) any changes in state or federal law with a direct impact on the underlying cost of providing home and community-based services; and

~~(9)~~ (10) outcome measures, determined by the commissioner, for home and community-based services rates determined under this section.

~~(e)~~ (c) The commissioner shall report to the chairs and the ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance with the information and data gathered under paragraphs ~~(b) to (d)~~ (a) and (b) on ~~the following dates:~~

~~(1) January 15, 2015, with preliminary results and data;~~

~~(2) January 15, 2016, with a status implementation update, and additional data and summary information;~~

~~(3) January 15, 2017, with the full report; and~~

~~(4)~~ January 15, ~~2020~~ 2021, with ~~another~~ a full report, and a full report once every four years thereafter.

~~(f) The commissioner shall implement a regional adjustment factor to all rate calculations in subdivisions 6 to 9, effective no later than January 1, 2015.~~ (d) Beginning ~~July 1, 2017~~ January 1, 2022, the commissioner shall renew analysis and implement changes to the regional adjustment factors ~~when adjustments required under subdivision 5, paragraph (h), occur~~ once every six years. Prior to implementation, the commissioner shall consult with stakeholders on the methodology to calculate the adjustment.

~~(g)~~ (e) The commissioner shall provide a public notice via LISTSERV in October of each year ~~beginning October 1, 2014,~~ containing information detailing legislatively approved changes in:

(1) calculation values including derived wage rates and related employee and administrative factors;

(2) service utilization;

(3) county and tribal allocation changes; and

(4) information on adjustments made to calculation values and the timing of those adjustments.

The information in this notice must be effective January 1 of the following year.

~~(h)~~ (f) When the available shared staffing hours in a residential setting are insufficient to meet the needs of an individual who enrolled in residential services after January 1, 2014, ~~or insufficient to meet the needs of an individual with a service agreement adjustment described in section 256B.4913, subdivision 4a, paragraph (f),~~ then individual staffing hours shall be used.

~~(i) The commissioner shall study the underlying cost of absence and utilization for day services. Based on the commissioner's evaluation of the data collected under this paragraph, the commissioner shall make recommendations to the legislature by January 15, 2018, for changes, if any, to the absence and utilization factor ratio component value for day services.~~

~~(j) Beginning July 1, 2017,~~ (g) The commissioner shall collect transportation and trip information for all day services through the rates management system.

(h) The commissioner, in consultation with stakeholders, shall study value-based models and outcome-based payment strategies for fee-for-service home and community-based services and report to the legislative committees with jurisdiction over the disability waiver rate system by October 1, 2020, with recommended strategies to: (1) promote new models of care, services, and reimbursement structures that require more efficient use of public dollars while improving the outcomes most valued by the individuals served; (2) assist clients and their families in evaluating options and stretching individual budget funds; (3) support individualized, person-centered planning and individual budget choices; and (4) create a broader range of client options geographically or targeted at culturally competent models for racial and ethnic minority groups.

**EFFECTIVE DATE.** This section is effective the day following final enactment, except the amendment to paragraph (f) is effective January 1, 2020.

Sec. 50. Minnesota Statutes 2018, section 256B.4914, subdivision 10a, is amended to read:

Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the service. As determined by the commissioner, in consultation with stakeholders identified in section 256B.4913, subdivision 5, a provider enrolled to provide services with rates determined under this section must submit requested cost data to the commissioner to support research on the cost of providing services that have rates determined by the disability waiver rates system. Requested cost data may include, but is not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

(5) vacation, sick, and training time paid;

(6) taxes, workers' compensation, and unemployment insurance costs paid;

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

(11) other data relating to costs required to provide services requested by the commissioner.

(b) At least once in any five-year period, a provider must submit cost data for a fiscal year that ended not more than 18 months prior to the submission date. The commissioner shall provide each provider a 90-day notice prior to its submission due date. If a provider fails to submit required reporting data, the commissioner shall provide notice to providers that have not provided required data 30 days after the required submission date, and a second notice for providers who have not provided required data 60 days after the required submission date. The commissioner shall temporarily suspend payments to the provider if cost data is not received 90 days after the required submission date. Withheld payments shall be made once data is received by the commissioner.

(c) The commissioner shall conduct a random validation of data submitted under paragraph (a) to ensure data accuracy. The commissioner shall analyze cost documentation in paragraph (a) and provide recommendations for adjustments to cost components.

(d) The commissioner shall analyze cost documentation in paragraph (a) and, in consultation with stakeholders identified in section 256B.4913, subdivision 5, may submit recommendations on component values and inflationary factor adjustments to the chairs and ranking minority members of the legislative committees with jurisdiction over human services every four years beginning January 1, 2020. The commissioner shall make recommendations in conjunction with reports submitted to the legislature according to subdivision 10, paragraph (e). The commissioner shall release cost data in an aggregate form, and cost data from individual providers shall not be released except as provided for in current law.

(e) The commissioner, in consultation with stakeholders identified in section 256B.4913, subdivision 5, shall develop and implement a process for providing training and technical assistance necessary to support provider submission of cost documentation required under paragraph (a).

(f) Beginning November 1, 2019, providers enrolled to provide services with rates determined under this section shall submit labor market data to the commissioner annually, including but not limited to:

(1) number of direct care staff;

(2) wages of direct care staff;

(3) overtime wages of direct care staff;

(4) hours worked by direct care staff;

(5) overtime hours worked by direct care staff;

(6) benefits provided to direct care staff;

(7) direct care staff job vacancies; and

(8) direct care staff retention rates.

(g) Beginning February 1, 2020, the commissioner shall publish annual reports on provider and state-level labor market data, including but not limited to the data obtained under paragraph (f).

(h) The commissioner shall temporarily suspend payments to the provider if data requested under paragraph (f) is not received 90 days after the required submission date. The commissioner shall make withheld payments once data is received by the commissioner.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 51. Minnesota Statutes 2018, section 256B.4914, subdivision 14, is amended to read:

Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead agencies must identify individuals with exceptional needs that cannot be met under the disability waiver rate system. The commissioner shall use that information to evaluate and, if necessary, approve an alternative payment rate for those individuals. Whether granted, denied, or modified, the commissioner shall respond to all exception requests in writing. The commissioner shall include in the written response the basis for the action and provide notification of the right to appeal under paragraph (h).

(b) Lead agencies must act on an exception request within 30 days and notify the initiator of the request of their recommendation in writing. A lead agency shall submit all exception requests along with its recommendation to the commissioner.

(c) An application for a rate exception may be submitted for the following criteria:

(1) an individual has service needs that cannot be met through additional units of service;

(2) an individual's rate determined under subdivisions 6, 7, 8, and 9 is so insufficient that it has resulted in an individual receiving a notice of discharge from the individual's provider; or

(3) an individual's service needs, including behavioral changes, require a level of service which necessitates a change in provider or which requires the current provider to propose service changes beyond those currently authorized.

(d) Exception requests must include the following information:

(1) the service needs required by each individual that are not accounted for in subdivisions 6, 7, 8, and 9;

(2) the service rate requested and the difference from the rate determined in subdivisions 6, 7, 8, and 9;

(3) a basis for the underlying costs used for the rate exception and any accompanying documentation; and

(4) any contingencies for approval.

(e) Approved rate exceptions shall be managed within lead agency allocations under sections 256B.092 and 256B.49.

(f) Individual disability waiver recipients, an interested party, or the license holder that would receive the rate exception increase may request that a lead agency submit an exception request. A lead agency that denies such a request shall notify the individual waiver recipient, interested party, or license holder of its decision and the reasons for denying the request in writing no later than 30 days after the request has been made and shall submit its denial to the commissioner in accordance with paragraph (b). The reasons for the denial must be based on the failure to meet the criteria in paragraph (c).

(g) The commissioner shall determine whether to approve or deny an exception request no more than 30 days after receiving the request. If the commissioner denies the request, the commissioner shall notify the lead agency and the individual disability waiver recipient, the interested party, and the license holder in writing of the reasons for the denial.

(h) The individual disability waiver recipient may appeal any denial of an exception request by either the lead agency or the commissioner, pursuant to sections 256.045 and 256.0451. When the denial of an exception request results in the proposed demission of a waiver recipient from a residential or day habilitation program, the commissioner shall issue a temporary stay of demission, when requested by the disability waiver recipient, consistent with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c). The temporary stay shall remain in effect until the lead agency can provide an informed choice of appropriate, alternative services to the disability waiver.

(i) Providers may petition lead agencies to update values that were entered incorrectly or erroneously into the rate management system, based on past service level discussions and determination in subdivision 4, without applying for a rate exception.

(j) The starting date for the rate exception will be the later of the date of the recipient's change in support or the date of the request to the lead agency for an exception.

(k) The commissioner shall track all exception requests received and their dispositions. The commissioner shall issue quarterly public exceptions statistical reports, including the number of exception requests received and the numbers granted, denied, withdrawn, and pending. The report shall include the average amount of time required to process exceptions.

~~(l) No later than January 15, 2016, the commissioner shall provide research findings on the estimated fiscal impact, the primary cost drivers, and common population characteristics of recipients with needs that cannot be met by the framework rates.~~

~~(m) No later than July 1, 2016, the commissioner shall develop and implement, in consultation with stakeholders, a process to determine eligibility for rate exceptions for individuals with rates determined under the methodology in section 256B.4913, subdivision 4a. Determination of eligibility for an exception will occur as annual service renewals are completed.~~

~~(n)~~ (l) Approved rate exceptions ~~will be implemented at such time that the individual's rate is no longer banded and~~ remain in effect in all cases until an individual's needs change as defined in paragraph (c).

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 52. Minnesota Statutes 2018, section 256B.4914, subdivision 15, is amended to read:

Subd. 15. **County or tribal allocations.** (a) ~~Upon implementation of the disability waiver rates management system on January 1, 2014,~~ The commissioner shall establish a method of tracking and reporting the fiscal impact of the disability waiver rates management system on individual lead agencies.

(b) ~~Beginning January 1, 2014,~~ The commissioner shall make annual adjustments to lead agencies' home and community-based waivered service budget allocations to adjust for rate differences and the resulting impact on county allocations upon implementation of the disability waiver rates system.

(c) Lead agencies exceeding their allocations shall be subject to the provisions under sections 256B.0916, subdivision 11, and 256B.49, subdivision 26.

Sec. 53. Minnesota Statutes 2018, section 256B.85, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** (a) CFSS is available to a person who meets one of the following:

(1) is an enrollee of medical assistance as determined under section 256B.055, 256B.056, or 256B.057, subdivisions 5 and 9;

(2) is a participant in the alternative care program under section 256B.0913;

(3) is a waiver participant as defined under section 256B.0915, 256B.092, 256B.093, or 256B.49; or

(4) has medical services identified in a person's individualized education program and is eligible for services as determined in section 256B.0625, subdivision 26.

(b) In addition to meeting the eligibility criteria in paragraph (a), a person must also meet all of the following:

(1) require assistance and be determined dependent in one activity of daily living or Level I behavior based on assessment under section 256B.0911; and

(2) is not a participant under a family support grant under section 252.32.

(c) A pregnant woman eligible for medical assistance under section 256B.055, subdivision 6, is eligible for CFSS without federal financial participation if the woman: (1) is eligible for CFSS under paragraphs (a) and (b); and (2) does not meet institutional level of care, as determined under section 256B.0911.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 54. Minnesota Statutes 2018, section 256B.85, is amended by adding a subdivision to read:

Subd. 7a. **Enhanced rate.** An enhanced rate of 107.5 percent of the rate paid for CFSS must be paid for services provided to persons who qualify for 12 or more hours of CFSS per day when provided by a support worker who meets the requirements of subdivision 16, paragraph (e). The enhanced rate for CFSS includes, and is not in addition to, any rate adjustments implemented by the commissioner on July 1, 2019, to comply with the terms of a collective bargaining agreement between the state of Minnesota and an exclusive representative of individual providers under section 179A.54 that provides for wage increases for individual providers who serve participants assessed to need 12 or more hours of CFSS per day.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 55. Minnesota Statutes 2018, section 256B.85, subdivision 10, is amended to read:

Subd. 10. **Agency-provider and FMS provider qualifications and duties.** (a) Agency-providers identified in subdivision 11 and FMS providers identified in subdivision 13a shall:

(1) enroll as a medical assistance Minnesota health care programs provider and meet all applicable provider standards and requirements;

(2) demonstrate compliance with federal and state laws and policies for CFSS as determined by the commissioner;

(3) comply with background study requirements under chapter 245C and maintain documentation of background study requests and results;

(4) verify and maintain records of all services and expenditures by the participant, including hours worked by support workers;

(5) not engage in any agency-initiated direct contact or marketing in person, by telephone, or other electronic means to potential participants, guardians, family members, or participants' representatives;

(6) directly provide services and not use a subcontractor or reporting agent;

(7) meet the financial requirements established by the commissioner for financial solvency;

(8) have never had a lead agency contract or provider agreement discontinued due to fraud, or have never had an owner, board member, or manager fail a state or FBI-based criminal background check while enrolled or seeking enrollment as a Minnesota health care programs provider; and

(9) have an office located in Minnesota.

(b) In conducting general duties, agency-providers and FMS providers shall:

(1) pay support workers based upon actual hours of services provided;

(2) pay for worker training and development services based upon actual hours of services provided or the unit cost of the training session purchased;

(3) withhold and pay all applicable federal and state payroll taxes;

(4) make arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

(5) enter into a written agreement with the participant, participant's representative, or legal representative that assigns roles and responsibilities to be performed before services, supports, or goods are provided;

(6) report maltreatment as required under sections 626.556 and 626.557; ~~and~~

(7) comply with any data requests from the department consistent with the Minnesota Government Data Practices Act under chapter 13~~.~~; and

(8) maintain documentation for the requirements under subdivision 16, paragraph (e), clause (2), to qualify for an enhanced rate under this section.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 56. Minnesota Statutes 2018, section 256B.85, subdivision 11, is amended to read:

Subd. 11. **Agency-provider model.** (a) The agency-provider model includes services provided by support workers and staff providing worker training and development services who are employed by an agency-provider that meets the criteria established by the commissioner, including required training.

(b) The agency-provider shall allow the participant to have a significant role in the selection and dismissal of the support workers for the delivery of the services and supports specified in the participant's CFSS service delivery plan.

(c) A participant may use authorized units of CFSS services as needed within a service agreement that is not greater than 12 months. Using authorized units in a flexible manner in either the agency-provider model or the budget model does not increase the total amount of services and supports authorized for a participant or included in the participant's CFSS service delivery plan.

(d) A participant may share CFSS services. Two or three CFSS participants may share services at the same time provided by the same support worker.

(e) The agency-provider must use a minimum of 72.5 percent of the revenue generated by the medical assistance payment for CFSS for support worker wages and benefits, except all of the revenue generated by a medical assistance rate increase due to a collective bargaining agreement under section 179A.54 must be used for support worker wages and benefits. The agency-provider must document how this requirement is being met. The revenue generated by the worker training and development services and the reasonable costs associated with the worker training and development services must not be used in making this calculation.

(f) The agency-provider model must be used by individuals who are restricted by the Minnesota restricted recipient program under Minnesota Rules, parts 9505.2160 to 9505.2245.

(g) Participants purchasing goods under this model, along with support worker services, must:

(1) specify the goods in the CFSS service delivery plan and detailed budget for expenditures that must be approved by the consultation services provider, case manager, or care coordinator; and

(2) use the FMS provider for the billing and payment of such goods.

Sec. 57. Minnesota Statutes 2018, section 256B.85, subdivision 12, is amended to read:

Subd. 12. **Requirements for enrollment of CFSS agency-providers.** (a) All CFSS agency-providers must provide, at the time of enrollment, reenrollment, and revalidation as a CFSS agency-provider in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the CFSS agency-provider's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage. Upon new enrollment, or if the agency-provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the agency-provider must purchase a surety bond of $50,000. If the agency-provider's Medicaid revenue in the previous calendar year is greater than $300,000, the agency-provider must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(3) proof of fidelity bond coverage in the amount of $20,000;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a description of the CFSS agency-provider's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors and owners to other service providers;

(7) a copy of the CFSS agency-provider's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer

safety, including the process for notification and resolution of participant grievances, incident response, identification and prevention of communicable diseases, and employee misconduct;

(8) copies of all other forms the CFSS agency-provider uses in the course of daily business including, but not limited to:

(i) a copy of the CFSS agency-provider's time sheet; and

(ii) a copy of the participant's individual CFSS service delivery plan;

(9) a list of all training and classes that the CFSS agency-provider requires of its staff providing CFSS services;

(10) documentation that the CFSS agency-provider and staff have successfully completed all the training required by this section;

(11) documentation of the agency-provider's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that are used or could be used for providing home care services;

(13) documentation that the agency-provider will use at least the following percentages of revenue generated from the medical assistance rate paid for CFSS services for CFSS support worker wages and benefits: 72.5 percent of revenue from CFSS providers, except 100 percent of the revenue generated by a medical assistance rate increase due to a collective bargaining agreement under section 179A.54 must be used for support worker wages and benefits. The revenue generated by the worker training and development services and the reasonable costs associated with the worker training and development services shall not be used in making this calculation; and

(14) documentation that the agency-provider does not burden participants' free exercise of their right to choose service providers by requiring CFSS support workers to sign an agreement not to work with any particular CFSS participant or for another CFSS agency-provider after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) CFSS agency-providers shall provide to the commissioner the information specified in paragraph (a).

(c) All CFSS agency-providers shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner. Employees in management and supervisory positions and owners who are

active in the day-to-day operations of an agency who have completed the required training as an employee with a CFSS agency-provider do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. CFSS agency-provider billing staff shall complete training about CFSS program financial management. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency.

(d) The commissioner shall send annual review notifications to agency-providers 30 days prior to renewal. The notification must:

(1) list the materials and information the agency-provider is required to submit;

(2) provide instructions on submitting information to the commissioner; and

(3) provide a due date by which the commissioner must receive the requested information.

Agency-providers shall submit all required documentation for annual review within 30 days of notification from the commissioner. If an agency-provider fails to submit all the required documentation, the commissioner may take action under subdivision 23a.

Sec. 58. Minnesota Statutes 2018, section 256B.85, subdivision 16, is amended to read:

Subd. 16. **Support workers requirements.** (a) Support workers shall:

(1) enroll with the department as a support worker after a background study under chapter 245C has been completed and the support worker has received a notice from the commissioner that the support worker:

(i) is not disqualified under section 245C.14; or

(ii) is disqualified, but has received a set-aside of the disqualification under section 245C.22;

(2) have the ability to effectively communicate with the participant or the participant's representative;

(3) have the skills and ability to provide the services and supports according to the participant's CFSS service delivery plan and respond appropriately to the participant's needs;

(4) complete the basic standardized CFSS training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. CFSS support worker training must include successful completion of the following training components: basic first aid,

vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of support workers including information about basic body mechanics, emergency preparedness, orientation to positive behavioral practices, orientation to responding to a mental health crisis, fraud issues, time cards and documentation, and an overview of person-centered planning and self-direction. Upon completion of the training components, the support worker must pass the certification test to provide assistance to participants;

(5) complete employer-directed training and orientation on the participant's individual needs;

(6) maintain the privacy and confidentiality of the participant; and

(7) not independently determine the medication dose or time for medications for the participant.

(b) The commissioner may deny or terminate a support worker's provider enrollment and provider number if the support worker:

(1) does not meet the requirements in paragraph (a);

(2) fails to provide the authorized services required by the employer;

(3) has been intoxicated by alcohol or drugs while providing authorized services to the participant or while in the participant's home;

(4) has manufactured or distributed drugs while providing authorized services to the participant or while in the participant's home; or

(5) has been excluded as a provider by the commissioner of human services, or by the United States Department of Health and Human Services, Office of Inspector General, from participation in Medicaid, Medicare, or any other federal health care program.

(c) A support worker may appeal in writing to the commissioner to contest the decision to terminate the support worker's provider enrollment and provider number.

(d) A support worker must not provide or be paid for more than 275 hours of CFSS per month, regardless of the number of participants the support worker serves or the number of agency-providers or participant employers by which the support worker is employed. The department shall not disallow the number of hours per day a support worker works unless it violates other law.

(e) CFSS qualify for an enhanced rate if the support worker providing the services:

(1) provides services, within the scope of CFSS described in subdivision 7, to a participant who qualifies for 12 or more hours per day of CFSS; and

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in the Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved training or competency requirements.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 59. Laws 2017, First Special Session chapter 6, article 1, section 45, is amended to read:

Sec. 45. **CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET METHODOLOGY ~~EXCEPTION FOR PERSONS LEAVING INSTITUTIONS AND CRISIS RESIDENTIAL SETTINGS~~.**

Subdivision 1. **Exception for persons leaving institutions and crisis residential settings.** (a) By September 30, 2017, the commissioner shall establish an institutional and crisis bed consumer-directed community supports budget exception process in the home and community-based services waivers under Minnesota Statutes, sections 256B.092 and 256B.49. This budget exception process shall be available for any individual who:

(1) is not offered available and appropriate services within 60 days since approval for discharge from the individual's current institutional setting; and

(2) requires services that are more expensive than appropriate services provided in a noninstitutional setting using the consumer-directed community supports option.

(b) Institutional settings for purposes of this exception include intermediate care facilities for persons with developmental disabilities; nursing facilities; acute care hospitals; Anoka Metro Regional Treatment Center; Minnesota Security Hospital; and crisis beds. The budget exception shall be limited to no more than the amount of appropriate services provided in a noninstitutional setting as determined by the lead agency managing the individual's home and community-based services waiver. The lead agency shall notify the Department of Human Services of the budget exception.

Subd. 2. **Shared services.** (a) Medical assistance payments for shared services under consumer-directed community supports are limited to this subdivision.

(b) For purposes of this subdivision, "shared services" means services provided at the same time by the same direct care worker for individuals who have entered into an agreement to share consumer-directed community support services.

(c) Shared services may include services in the personal assistance category as outlined in the consumer-directed community supports community support plan and shared services agreement, except:

(1) services for more than three individuals provided by one worker at one time;

(2) use of more than one worker for the shared services; and

(3) a child care program licensed under chapter 245A or operated by a local school district or private school.

(d) The individuals or, as needed, their representatives shall develop the plan for shared services when developing or amending the consumer-directed community supports plan, and must follow the consumer-directed community supports process for approval of the plan by the lead agency. The plan for shared services in an individual's consumer-directed community supports plan shall include the intention to utilize shared services based on individuals' needs and preferences.

(e) Individuals sharing services must use the same financial management services provider.

(f) Individuals whose consumer-directed community supports community support plans include the intention to utilize shared services must also jointly develop, with the support of their representatives as needed, a shared services agreement. This agreement must include:

(1) the names of the individuals receiving shared services;

(2) the individuals' representative, if identified in their consumer-directed community supports plans, and their duties;

(3) the names of the case managers;

(4) the financial management services provider;

(5) the shared services that must be provided;

(6) the schedule for shared services;

(7) the location where shared services must be provided;

(8) the training specific to each individual served;

(9) the training specific to providing shared services to the individuals identified in the agreement;

(10) instructions to follow all required documentation for time and services provided;

(11) a contingency plan for each of the individuals that accounts for service provision and billing in the absence of one of the individuals in a shared services setting due to illness or other circumstances;

(12) signatures of all parties involved in the shared services; and

(13) agreement by each of the individuals who are sharing services on the number of shared hours for services provided.

(g) Any individual or any individual's representative may withdraw from participating in a shared services agreement at any time.

(h) The lead agency for each individual must authorize the use of the shared services option based on the criteria that the shared service is appropriate to meet the needs, health, and safety of each individual for whom they provide case management or care coordination.

(i) Nothing in this subdivision must be construed to reduce the total authorized consumer-directed community supports budget for an individual.

(j) No later than September 30, 2019, the commissioner of human services shall:

(1) submit an amendment to the Centers for Medicare and Medicaid Services for the home and community-based services waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49, to allow for a shared services option under consumer-directed community supports; and

(2) with stakeholder input, develop guidance for shared services in consumer-directed community-supports within the Community Based Services Manual. Guidance must include:

(i) recommendations for negotiating payment for one-to-two and one-to-three services; and

(ii) a template of the shared services agreement.

**EFFECTIVE DATE.** This section is effective October 1, 2019, or upon federal approval, whichever is later, except for subdivision 2, paragraph (j), which is effective the day following final enactment. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 60. Laws 2017, First Special Session chapter 6, article 3, section 49, is amended to read:

Sec. 49. **ELECTRONIC ~~SERVICE DELIVERY DOCUMENTATION SYSTEM~~ VISIT VERIFICATION.**

Subdivision 1. **Documentation; establishment.** The commissioner of human services shall establish implementation requirements and standards for ~~an~~ electronic ~~service delivery documentation system~~ visit verification to comply with the 21st Century Cures Act, Public Law 114-255. Within available appropriations, the commissioner shall take steps to comply with the electronic visit verification requirements in the 21st Century Cures Act, Public Law 114-255.

Subd. 2. **Definitions.** (a) For purposes of this section, the terms in this subdivision have the meanings given them.

(b) "Electronic ~~service delivery documentation~~ visit verification" means the electronic documentation of the:

(1) type of service performed;

(2) individual receiving the service;

(3) date of the service;

(4) location of the service delivery;

(5) individual providing the service; and

(6) time the service begins and ends.

(c) "Electronic ~~service delivery documentation~~ visit verification system" means a system that provides electronic ~~service delivery documentation~~ verification of services that complies with the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision 3.

(d) "Service" means one of the following:

(1) personal care assistance services as defined in Minnesota Statutes, section 256B.0625, subdivision 19a, and provided according to Minnesota Statutes, section 256B.0659; ~~or~~

(2) community first services and supports under Minnesota Statutes, section 256B.85;

(3) home health services under Minnesota Statutes, section 256B.0625, subdivision 6a; or

(4) other medical supplies and equipment or home and community-based services that are required to be electronically verified by the 21st Century Cures Act, Public Law 114-255.

Subd. 3. **Requirements.** (a) In developing implementation requirements for ~~an~~ electronic ~~service delivery documentation system~~ visit verification, the commissioner shall ~~consider electronic visit verification systems and other electronic service delivery documentation methods. The commissioner shall convene stakeholders that will be impacted by an electronic service delivery system, including service providers and their representatives, service recipients and their representatives, and, as appropriate, those with expertise in the development and operation of an electronic service delivery documentation system, to~~ ensure that the requirements:

(1) are minimally administratively and financially burdensome to a provider;

(2) are minimally burdensome to the service recipient and the least disruptive to the service recipient in receiving and maintaining allowed services;

(3) consider existing best practices and use of electronic ~~service delivery documentation~~ visit verification;

(4) are conducted according to all state and federal laws;

(5) are effective methods for preventing fraud when balanced against the requirements of clauses (1) and (2); and

(6) are consistent with the Department of Human Services' policies related to covered services, flexibility of service use, and quality assurance.

(b) The commissioner shall make training available to providers on the electronic ~~service delivery documentation~~ visit verification system requirements.

(c) The commissioner shall establish baseline measurements related to preventing fraud and establish measures to determine the effect of electronic ~~service delivery documentation~~ visit verification requirements on program integrity.

(d) The commissioner shall make a state-selected electronic visit verification system available to providers of services.

Subd. 3a. **Provider requirements.** (a) A provider of services may select any electronic visit verification system that meets the requirements established by the commissioner.

(b) All electronic visit verification systems used by providers to comply with the requirements established by the commissioner must provide data to the commissioner in a format and at a frequency to be established by the commissioner.

(c) Providers must implement the electronic visit verification systems required under this section by a date established by the commissioner to be set after the state-selected electronic visit verification systems for personal care services and home health services are in production. For purposes of this paragraph, "personal care services" and "home health services" have the meanings given in United States Code, title 42, section 1396b(l)(5). Reimbursement rates for providers must not be reduced as a result of federal action to reduce the federal medical assistance percentage under the 21st Century Cures Act, Public Law 114-255.

~~Subd. 4. **Legislative report.** (a) The commissioner shall submit a report by January 15, 2018, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services with recommendations, based on the requirements of subdivision 3, to establish electronic service delivery documentation system requirements and standards. The report shall identify:~~

~~(1) the essential elements necessary to operationalize a base-level electronic service delivery documentation system to be implemented by January 1, 2019; and~~

~~(2) enhancements to the base-level electronic service delivery documentation system to be implemented by January 1, 2019, or after, with projected operational costs and the costs and benefits for system enhancements.~~

~~(b) The report must also identify current regulations on service providers that are either inefficient, minimally effective, or will be unnecessary with the implementation of an electronic service delivery documentation system.~~

Sec. 61. **INDIVIDUAL PROVIDERS OF DIRECT SUPPORT SERVICES.**

The labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota, submitted to the Legislative Coordinating Commission on March 11, 2019, is ratified.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 62. **RATE INCREASE FOR DIRECT SUPPORT SERVICES PROVIDERS WORKFORCE NEGOTIATIONS.**

(a) Effective July 1, 2019, if the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved pursuant to Minnesota Statutes, section 3.855, the commissioner of human services shall:

(1) increase reimbursement rates, individual budgets, grants, or allocations by 2.37 percent for services provided on or after July 1, 2019, to implement the minimum hourly wage, holiday, and paid time off provisions of that agreement; and

(2) for services provided on or after July 1, 2019, to eligible service recipients, provide an enhanced rate of 7.5 percent for personal care assistance and community first services and supports and an enhanced budget increased by 7.5 percent for consumer-directed community supports and the consumer support grant. Eligible service recipients are persons identified by the state through assessment who are eligible for at least 12 hours of personal care assistance each day and are served by workers who have completed designated training approved by the commissioner. The enhanced rate and enhanced budget includes, and is not in addition to, any previously implemented enhanced rates or enhanced budgets for eligible service recipients.

(b) The rate changes described in this section apply to direct support services provided through a covered program, as defined in Minnesota Statutes, section 256B.0711, subdivision 1.

Sec. 63. **DIRECTION TO COMMISSIONER; SKILLED NURSE VISIT RATES.**

The commissioner of human services shall ensure that skilled nurse visits reimbursed under Minnesota Statutes, section 256B.0653, are coded, specific to the category of the nurse performing the visit, using code sets compliant with the Health Insurance Portability and Accountability Act, Public Law 104-191. "Skilled nurse visit" has the meaning given in Minnesota Statutes, section 256B.0653, subdivision 2, paragraph (j).

Sec. 64. **DIRECTION TO COMMISSIONER; INTERAGENCY AGREEMENTS.**

By October 1, 2019, the Department of Commerce, Public Utilities Commission, and Department of Human Services must amend all interagency agreements necessary to implement sections 1 to 10.

Sec. 65. **DIRECTION TO COMMISSIONER; FEDERAL AUTHORITY FOR RECONFIGURED WAIVER SERVICES.**

The commissioner of human services shall seek necessary federal authority to implement new and reconfigured waiver services under section 66. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained and when new services are fully implemented.

Sec. 66. **DISABILITY WAIVER RECONFIGURATION.**

Subdivision 1. **Intent.** It is the intent of the legislature to reform the medical assistance waiver programs for people with disabilities to simplify administration of the programs, incentivize inclusive person-centered supports, enhance each person's personal authority over the person's service choice, align benefits across waivers, encourage equity across programs and populations, and promote long-term sustainability of needed services. To the maximum extent possible, the disability waiver reconfiguration must maintain service stability and continuity of care, while promoting the most independent and integrated supports of each person's choosing in both short- and long-term planning.

Subd. 2. **Report.** By January 15, 2021, the commissioner of human services shall submit a report to the members of the legislative committees with jurisdiction over human services on any necessary waivers, state plan amendments, requests for new funding or realignment of existing funds, any changes to state statute or rule, and any other federal authority necessary to implement this section. The report must include information about the commissioner's work to collect feedback and input from providers, persons accessing home and community-based services waivers and their families, and client advocacy organizations.

Subd. 3. **Proposal.** By January 15, 2021, the commissioner shall develop a proposal to reconfigure the medical assistance waivers provided in sections 256B.092 and 256B.49. The proposal shall include all necessary plans for implementing two home and community-based services waiver programs, as authorized under section 1915(c) of the Social Security Act that serve persons who are determined to require the levels of care provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities. Before submitting the final report to the legislature, the commissioner shall publish a draft report with sufficient time for interested persons to offer additional feedback.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 67. **DIRECT CARE WORKFORCE RATE METHODOLOGY STUDY.**

The commissioner of human services, in consultation with stakeholders, shall evaluate the feasibility of developing a rate methodology for the personal care assistance program, under Minnesota Statutes, section 256B.0659, and community first services and supports, under Minnesota Statutes, section 256B.85, similar to the disability waiver rate system under Minnesota Statutes, section 256B.4914, including determining the component values and factors to include in such a rate methodology; consider aligning any rate methodology with the collective bargaining agreement and negotiation cycle under Minnesota Statutes,

section 179A.54; recommend strategies for ensuring adequate, competitive wages for direct care workers; develop methods and determine the necessary resources for the commissioner to more consistently collect and audit data from the direct care industry; and report recommendations, including proposed legislation, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance by February 1, 2020.

Sec. 68. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; TEFRA OPTION IMPROVEMENT MEASURES.**

(a) The commissioner of human services shall, using existing appropriations, develop content to be included on the MNsure website explaining the TEFRA option under medical assistance for applicants who indicate during the application process that a child in the family has a disability.

(b) The commissioner shall develop a cover letter explaining the TEFRA option under medical assistance, as well as the application and renewal process, to be disseminated with the DHS-6696A form to applicants who may qualify for medical assistance under the TEFRA option. The commissioner shall provide the content and the form to the executive director of MNsure for inclusion on the MNsure website. The commissioner shall also develop and implement education and training for lead agency staff statewide to improve understanding of the medical assistance TEFRA enrollment and renewal processes and procedures.

(c) The commissioner shall convene a stakeholder group that shall consider improvements to the TEFRA option enrollment and renewal processes, including but not limited to revisions to, or the development of, application and renewal paperwork specific to the TEFRA option; possible technology solutions; and county processes.

(d) The stakeholder group must include representatives from the Department of Human Services Health Care Division, MNsure, representatives from at least two counties in the metropolitan area and from at least one county in greater Minnesota, the Arc Minnesota, Gillette Children's Specialty Healthcare, the Autism Society of Minnesota, Proof Alliance, the Minnesota Consortium for Citizens with Disabilities, and other interested stakeholders as identified by the commissioner of human services.

(e) The stakeholder group shall submit a report of the group's recommended improvements and any associated costs to the commissioner by December 31, 2020. The group shall also provide copies of the report to each stakeholder group member. The commissioner shall provide a copy of the report to the legislative committees with jurisdiction over medical assistance.

Sec. 69. **DIRECTION TO COMMISSIONER; DIRECT CARE STAFF COMPENSATION REPORT.**

By January 15, 2022, the commissioner of human services, in consultation with stakeholders, shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance with recommendations for:

(1) the implementation of penalties for providers who do not meet the compensation levels identified in Minnesota Statutes, section 256B.4914, subdivision 5a;

(2) the implementation of good cause exemptions for providers who have not met the compensation levels identified in Minnesota Statutes, section 256B.4914, subdivision 5a; and

(3) the rebasing of compensation levels identified in Minnesota Statutes, section 256B.4914, subdivision 5a, using data reported under Minnesota Statutes, section 256B.4914, subdivision 10a.

Sec. 70. **REVISOR INSTRUCTION.**

The revisor of statutes, in consultation with the House Research Department, Office of Senate Counsel, Research and Fiscal Analysis, and Department of Human Services, shall prepare legislation for the 2020 legislative session to codify laws governing consumer-directed community supports in Minnesota Statutes, chapter 256B.

Sec. 71. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 256B.4913, subdivision 5, as a subdivision in Minnesota Statutes, section 256B.4914. The revisor shall also make necessary cross-reference changes in Minnesota Statutes consistent with the renumbering.

Sec. 72. **REPEALER.**

(a) Minnesota Statutes 2018, section 256B.0705, is repealed.

(b) Minnesota Statutes 2018, sections 252.431; and 252.451, are repealed.

(c) Minnesota Statutes 2018, sections 252.41, subdivision 8; and 256B.4913, subdivisions 4a, 6, and 7, are repealed.

**EFFECTIVE DATE.** Paragraph (a) is effective the day following final enactment. Paragraph (b) is effective September 1, 2019. Paragraph (c) is effective January 1, 2020.

## ARTICLE 6
## CHEMICAL AND MENTAL HEALTH

Section 1. Minnesota Statutes 2018, section 13.851, is amended by adding a subdivision to read:

Subd. 12. **Mental health screening.** The treatment of data collected by a sheriff or local corrections agency related to individuals who may have a mental illness is governed by section 641.15, subdivision 3a.

Sec. 2. Minnesota Statutes 2018, section 245.4661, subdivision 9, is amended to read:

Subd. 9. **Services and programs.** (a) The following ~~three~~ four distinct grant programs are funded under this section:

(1) mental health crisis services;

(2) housing with supports for adults with serious mental illness; ~~and~~

(3) projects for assistance in transitioning from homelessness (PATH program)~~.~~; and

(4) culturally specific mental health and substance use disorder provider consultation.

(b) In addition, the following are eligible for grant funds:

(1) community education and prevention;

(2) client outreach;

(3) early identification and intervention;

(4) adult outpatient diagnostic assessment and psychological testing;

(5) peer support services;

(6) community support program services (CSP);

(7) adult residential crisis stabilization;

(8) supported employment;

(9) assertive community treatment (ACT);

(10) housing subsidies;

(11) basic living, social skills, and community intervention;

(12) emergency response services;

(13) adult outpatient psychotherapy;

(14) adult outpatient medication management;

(15) adult mobile crisis services;

(16) adult day treatment;

(17) partial hospitalization;

(18) adult residential treatment;

(19) adult mental health targeted case management;

(20) intensive community rehabilitative services (ICRS); and

(21) transportation.

Sec. 3. Minnesota Statutes 2018, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 124D.23 or 245.493; or

(4) mental health service providers.

(b) The following services are eligible for grants under this section:

(1) services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with severe emotional disturbances who are at risk of out-of-home placement;

(4) children's mental health crisis services;

(5) mental health services for people from cultural and ethnic minorities;

(6) children's mental health screening and follow-up diagnostic assessment and treatment;

(7) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(8) school-linked mental health services~~, including transportation for children receiving school-linked mental health services when school is not in session~~ under section 245.4901;

(9) building evidence-based mental health intervention capacity for children birth to age five;

(10) suicide prevention and counseling services that use text messaging statewide;

(11) mental health first aid training;

(12) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma;

(13) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(14) early childhood mental health consultation;

(15) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(16) psychiatric consultation for primary care practitioners; and

(17) providers to begin operations and meet program requirements when establishing a new children's mental health program. These may be start-up grants.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

(d) As a condition of receiving grant funds, a grantee shall obtain all available third-party reimbursement sources, if applicable.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 4. **[245.4901] SCHOOL-LINKED MENTAL HEALTH GRANTS.**

Subdivision 1. **Establishment.** The commissioner of human services shall establish a school-linked mental health grant program to provide early identification and intervention for students with mental health needs and to build the capacity of schools to support students with mental health needs in the classroom.

Subd. 2. **Eligible applicants.** An eligible applicant for school-linked mental health grants is an entity that is:

(1) certified under Minnesota Rules, parts 9520.0750 to 9520.0870;

(2) a community mental health center under section 256B.0625, subdivision 5;

(3) an Indian health service facility or a facility owned and operated by a tribe or tribal organization operating under United States Code, title 25, section 5321;

(4) a provider of children's therapeutic services and supports as defined in section 256B.0943; or

(5) enrolled in medical assistance as a mental health or substance use disorder provider agency and employs at least two full-time equivalent mental health professionals qualified according to section 245I.16, subdivision 2, or two alcohol and drug counselors licensed or exempt from licensure under chapter 148F who are qualified to provide clinical services to children and families.

Subd. 3. **Allowable grant activities and related expenses.** (a) Allowable grant activities and related expenses may include but are not limited to:

(1) identifying and diagnosing mental health conditions of students;

(2) delivering mental health treatment and services to students and their families, including via telemedicine consistent with section 256B.0625, subdivision 3b;

(3) supporting families in meeting their child's needs, including navigating health care, social service, and juvenile justice systems;

(4) providing transportation for students receiving school-linked mental health services when school is not in session;

(5) building the capacity of schools to meet the needs of students with mental health concerns, including school staff development activities for licensed and nonlicensed staff; and

(6) purchasing equipment, connection charges, on-site coordination, set-up fees, and site fees in order to deliver school-linked mental health services via telemedicine.

(b) Grantees shall obtain all available third-party reimbursement sources as a condition of receiving a grant. For purposes of this grant program, a third-party reimbursement source excludes a public school as defined in section 120A.20, subdivision 1. Grantees shall serve students regardless of health coverage status or ability to pay.

Subd. 4. **Data collection and outcome measurement.** Grantees shall provide data to the commissioner for the purpose of evaluating the effectiveness of the school-linked mental health grant program.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 5. Minnesota Statutes 2018, section 245.735, subdivision 3, is amended to read:

Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall establish a state certification process for certified community behavioral health clinics (CCBHCs) ~~to be eligible for the prospective payment system in paragraph (f)~~. Entities that choose to be CCBHCs must:

(1) comply with the CCBHC criteria published by the United States Department of Health and Human Services;

(2) employ or contract for clinic staff who have backgrounds in diverse disciplines, including licensed mental health professionals and licensed alcohol and drug counselors, and staff who are culturally and linguistically trained to ~~serve~~ meet the needs of the ~~clinic's patient~~ population the clinic serves;

(3) ensure that clinic services are available and accessible to ~~patients~~ individuals and families of all ages and genders and that crisis management services are available 24 hours per day;

(4) establish fees for clinic services for ~~nonmedical assistance patients~~ individuals who are not enrolled in medical assistance using a sliding fee scale that ensures that services to patients are not denied or limited due to ~~a patient's~~ an individual's inability to pay for services;

(5) comply with quality assurance reporting requirements and other reporting requirements, including any required reporting of encounter data, clinical outcomes data, and quality data;

(6) provide crisis mental health and substance use services, withdrawal management services, emergency crisis intervention services, and stabilization services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; ~~patient-centered~~ person- and family-centered treatment planning; outpatient mental health and substance use services; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family support services; and intensive community-based mental health services, including mental health services for members of the armed forces and veterans;

(7) provide coordination of care across settings and providers to ensure seamless transitions for ~~patients~~ individuals being served across the full spectrum of health services, including acute, chronic, and behavioral needs. Care coordination may be accomplished through partnerships or formal contracts with:

(i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or community-based mental health providers; and

(ii) other community services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally licensed health care and mental health facilities, urban Indian health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics;

(8) be certified as mental health clinics under section 245.69, subdivision 2;

~~(9) be certified to provide integrated treatment for co-occurring mental illness and substance use disorders in adults or children under Minnesota Rules, chapter 9533, effective July 1, 2017;~~

~~(10)~~ (9) comply with standards relating to mental health services in ~~Minnesota Rules, parts 9505.0370 to 9505.0372~~ chapter 245I and section 256B.0671;

~~(11)~~ (10) be licensed to provide ~~chemical dependency~~ substance use disorder treatment under chapter 245G;

~~(12)~~ (11) be certified to provide children's therapeutic services and supports under section 256B.0943;

~~(13)~~ (12) be certified to provide adult rehabilitative mental health services under section 256B.0623;

~~(14)~~ (13) be enrolled to provide mental health crisis response services under ~~section~~ sections 256B.0624 and 256B.0944;

~~(15)~~ (14) be enrolled to provide mental health targeted case management under section 256B.0625, subdivision 20;

~~(16)~~ (15) comply with standards relating to mental health case management in Minnesota Rules, parts 9520.0900 to 9520.0926; ~~and~~

~~(17)~~ (16) provide services that comply with the evidence-based practices described in paragraph (e)~~.~~; and

(17) comply with standards relating to peer services under sections 256B.0615, 256B.0616, and 245G.07, subdivision 1, paragraph (a), clause (5), as applicable when peer services are provided.

(b) If an entity is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the commissioner may certify the entity as a CCBHC, if the entity has a current contract with another entity that has the required authority to provide that service and that meets federal CCBHC criteria as a designated collaborating organization, or, to the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral arrangement. The CCBHC must meet federal requirements regarding the type and scope of services to be provided directly by the CCBHC.

(c) Notwithstanding any other law that requires a county contract or other form of county approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets CCBHC requirements may receive the prospective payment under ~~paragraph (f)~~ section 256B.0625, subdivision 5m, for those services without a county contract or county approval. There is no county share when medical assistance pays the CCBHC prospective payment. As part of the certification process in paragraph (a), the commissioner shall require a letter of support from the CCBHC's host county confirming that the CCBHC and the county or counties it serves have an ongoing relationship to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.

(d) When the standards listed in paragraph (a) or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders, as described in subdivision 4, before granting variances under this provision. For the CCBHC that is certified but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

(e) The commissioner shall issue a list of required evidence-based practices to be delivered by CCBHCs, and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. The commissioner shall take into consideration the adequacy of evidence to support the efficacy of the practice, the quality of workforce available, and the current availability of the practice in the state.

At least 30 days before issuing the initial list and any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

~~(f) The commissioner shall establish standards and methodologies for a prospective payment system for medical assistance payments for services delivered by certified community behavioral health clinics, in accordance with guidance issued by the Centers for Medicare and Medicaid Services. During the operation of the demonstration project, payments shall comply with federal requirements for an enhanced federal medical assistance percentage. The commissioner may include quality bonus payment in the prospective payment system based on federal criteria and on a clinic's provision of the evidence-based practices in paragraph (e). The prospective payment system does not apply to MinnesotaCare. Implementation of the prospective payment system is effective July 1, 2017, or upon federal approval, whichever is later.~~

~~(g) The commissioner shall seek federal approval to continue federal financial participation in payment for CCBHC services after the federal demonstration period ends for clinics that were certified as CCBHCs during the demonstration period and that continue to meet the CCBHC certification standards in paragraph (a). Payment for CCBHC services shall cease effective July 1, 2019, if continued federal financial participation for the payment of CCBHC services cannot be obtained.~~

~~(h) The commissioner may certify at least one CCBHC located in an urban area and at least one CCBHC located in a rural area, as defined by federal criteria. To the extent allowed by federal law, the commissioner may limit the number of certified clinics so that the projected claims for certified clinics will not exceed the funds budgeted for this purpose. The commissioner shall give preference to clinics that:~~

~~(1) provide a comprehensive range of services and evidence-based practices for all age groups, with services being fully coordinated and integrated; and~~

~~(2) enhance the state's ability to meet the federal priorities to be selected as a CCBHC demonstration state.~~

~~(i)~~ (f) The commissioner shall recertify CCBHCs at least every three years. The commissioner shall establish a process for decertification and shall require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section or that fails to meet the standards provided by the commissioner in the application and certification process.

**EFFECTIVE DATE.** This section is effective July 1, 2019, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 6. Minnesota Statutes 2018, section 245F.05, subdivision 2, is amended to read:

Subd. 2. **Admission criteria.** For an individual to be admitted to a withdrawal management program, the program must make a determination that the program services are appropriate to the needs of the individual. A program may only admit individuals ~~who meet the admission criteria and~~ who, at the time of admission~~:~~, meet the criteria for admission as determined by current American Society of Addiction Medicine standards for appropriate level of withdrawal management.

~~(1) are impaired as the result of intoxication;~~

~~(2) are experiencing physical, mental, or emotional problems due to intoxication or withdrawal from alcohol or other drugs;~~

~~(3) are being held under apprehend and hold orders under section 253B.07, subdivision 2b;~~

~~(4) have been committed under chapter 253B and need temporary placement;~~

~~(5) are held under emergency holds or peace and health officer holds under section 253B.05, subdivision 1 or 2; or~~

~~(6) need to stay temporarily in a protective environment because of a crisis related to substance use disorder. Individuals satisfying this clause may be admitted only at the request of the county of fiscal responsibility, as determined according to section 256G.02, subdivision 4. Individuals admitted according to this clause must not be restricted to the facility.~~

Sec. 7. Minnesota Statutes 2018, section 254A.03, subdivision 3, is amended to read:

Subd. 3. **Rules for substance use disorder care.** (a) The commissioner of human services shall establish by rule criteria to be used in determining the appropriate level of chemical dependency care for each recipient of public assistance seeking treatment for substance misuse or substance use disorder. Upon federal approval of a comprehensive assessment as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding the criteria in Minnesota Rules, parts 9530.6600 to 9530.6655, an eligible vendor of comprehensive assessments under section 254B.05 may determine and approve the appropriate level of substance use disorder treatment for a recipient of public assistance. The process for determining an individual's financial eligibility for the consolidated chemical

dependency treatment fund or determining an individual's enrollment in or eligibility for a publicly subsidized health plan is not affected by the individual's choice to access a comprehensive assessment for placement.

(b) The commissioner shall develop and implement a utilization review process for publicly funded treatment placements to monitor and review the clinical appropriateness and timeliness of all publicly funded placements in treatment.

(c) If a screen result is positive for alcohol or substance misuse, a brief screening for alcohol or substance use disorder that is provided to a recipient of public assistance within a primary care clinic, hospital, or other medical setting or school setting establishes medical necessity and approval for an initial set of substance use disorder services identified in section 254B.05, subdivision 5. The initial set of services approved for a recipient whose screen result is positive may include any combination of up to four hours of individual or group substance use disorder treatment, two hours of substance use disorder treatment coordination, or two hours of substance use disorder peer support services provided by a qualified individual according to chapter 245G. A recipient must obtain an assessment pursuant to paragraph (a) to be approved for additional treatment services.

**EFFECTIVE DATE.** Contingent upon federal approval, this section is effective July 1, 2019. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained or denied.

Sec. 8. Minnesota Statutes 2018, section 254B.02, subdivision 1, is amended to read:

Subdivision 1. **Chemical dependency treatment allocation.** The chemical dependency treatment appropriation shall be placed in a special revenue account. ~~The commissioner shall annually transfer funds from the chemical dependency fund to pay for operation of the drug and alcohol abuse normative evaluation system and to pay for all costs incurred by adding two positions for licensing of chemical dependency treatment and rehabilitation programs located in hospitals for which funds are not otherwise appropriated.~~ The ~~remainder of the~~ money in the special revenue account must be used according to the requirements in this chapter.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 9. Minnesota Statutes 2018, section 254B.03, subdivision 2, is amended to read:

Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical dependency fund is limited to payments for services other than detoxification licensed under

Minnesota Rules, parts 9530.6510 to 9530.6590, that, if located outside of federally recognized tribal lands, would be required to be licensed by the commissioner as a chemical dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and services other than detoxification provided in another state that would be required to be licensed as a chemical dependency program if the program were in the state. Out of state vendors must also provide the commissioner with assurances that the program complies substantially with state licensing requirements and possesses all licenses and certifications required by the host state to provide chemical dependency treatment. Vendors receiving payments from the chemical dependency fund must not require co-payment from a recipient of benefits for services provided under this subdivision. The vendor is prohibited from using the client's public benefits to offset the cost of services paid under this section. The vendor shall not require the client to use public benefits for room or board costs. This includes but is not limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP benefits. Retention of SNAP benefits is a right of a client receiving services through the consolidated chemical dependency treatment fund or through state contracted managed care entities. Payment from the chemical dependency fund shall be made for necessary room and board costs provided by vendors ~~certified according to~~ meeting the criteria under section 254B.05, subdivision 1a, or in a community hospital licensed by the commissioner of health according to sections 144.50 to 144.56 to a client who is:

(1) determined to meet the criteria for placement in a residential chemical dependency treatment program according to rules adopted under section 254A.03, subdivision 3; and

(2) concurrently receiving a chemical dependency treatment service in a program licensed by the commissioner and reimbursed by the chemical dependency fund.

(b) A county may, from its own resources, provide chemical dependency services for which state payments are not made. A county may elect to use the same invoice procedures and obtain the same state payment services as are used for chemical dependency services for which state payments are made under this section if county payments are made to the state in advance of state payments to vendors. When a county uses the state system for payment, the commissioner shall make monthly billings to the county using the most recent available information to determine the anticipated services for which payments will be made in the coming month. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.

(c) The commissioner shall coordinate chemical dependency services and determine whether there is a need for any proposed expansion of chemical dependency treatment

services. The commissioner shall deny vendor certification to any provider that has not received prior approval from the commissioner for the creation of new programs or the expansion of existing program capacity. The commissioner shall consider the provider's capacity to obtain clients from outside the state based on plans, agreements, and previous utilization history, when determining the need for new treatment services.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 10. Minnesota Statutes 2018, section 254B.03, subdivision 4, is amended to read:

Subd. 4. **Division of costs.** (a) Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69, the county shall, out of local money, pay the state for 22.95 percent of the cost of chemical dependency services, ~~including~~ except for those services provided to persons ~~eligible for~~ enrolled in medical assistance under chapter 256B and room and board services under section 254B.05, subdivision 5, paragraph (b), clause (12). Counties may use the indigent hospitalization levy for treatment and hospital payments made under this section.

(b) 22.95 percent of any state collections from private or third-party pay, less 15 percent for the cost of payment and collections, must be distributed to the county that paid for a portion of the treatment under this section.

~~(c) For fiscal year 2017 only, the 22.95 percentages under paragraphs (a) and (b) are equal to 20.2 percent.~~

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 11. Minnesota Statutes 2018, section 254B.04, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, ~~and persons eligible for medical assistance benefits under sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 5, and 6, or~~ who meet the income standards of section 256B.056, subdivision 4, and are not enrolled in medical assistance, are entitled to chemical dependency fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(b) Persons with dependent children who are determined to be in need of chemical dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a

facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

(c) Notwithstanding paragraph (a), persons enrolled in medical assistance are eligible for room and board services under section 254B.05, subdivision 5, paragraph (b), clause (12).

**EFFECTIVE DATE.** This section is effective September 1, 2019.

Sec. 12. Minnesota Statutes 2018, section 254B.05, subdivision 1a, is amended to read:

Subd. 1a. **Room and board provider requirements.** (a) Effective January 1, 2000, vendors of room and board are eligible for chemical dependency fund payment if the vendor:

(1) has rules prohibiting residents bringing chemicals into the facility or using chemicals while residing in the facility and provide consequences for infractions of those rules;

(2) is determined to meet applicable health and safety requirements;

(3) is not a jail or prison;

(4) is not concurrently receiving funds under chapter 256I for the recipient;

(5) admits individuals who are 18 years of age or older;

(6) is registered as a board and lodging or lodging establishment according to section 157.17;

(7) has awake staff on site 24 hours per day;

(8) has staff who are at least 18 years of age and meet the requirements of section 245G.11, subdivision 1, paragraph (b);

(9) has emergency behavioral procedures that meet the requirements of section 245G.16;

(10) meets the requirements of section 245G.08, subdivision 5, if administering medications to clients;

(11) meets the abuse prevention requirements of section 245A.65, including a policy on fraternization and the mandatory reporting requirements of section 626.557;

(12) documents coordination with the treatment provider to ensure compliance with section 254B.03, subdivision 2;

(13) protects client funds and ensures freedom from exploitation by meeting the provisions of section 245A.04, subdivision 13;

(14) has a grievance procedure that meets the requirements of section 245G.15, subdivision 2; and

(15) has sleeping and bathroom facilities for men and women separated by a door that is locked, has an alarm, or is supervised by awake staff.

(b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (15).

(c) Licensed programs providing intensive residential treatment services or residential crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors of room and board and are exempt from paragraph (a), clauses (6) to (15).

**EFFECTIVE DATE.** This section is effective September 1, 2019.

Sec. 13. Minnesota Statutes 2018, section 254B.06, subdivision 1, is amended to read:

Subdivision 1. **State collections.** The commissioner is responsible for all collections from persons determined to be partially responsible for the cost of care of an eligible person receiving services under Laws 1986, chapter 394, sections 8 to 20. The commissioner may initiate, or request the attorney general to initiate, necessary civil action to recover the unpaid cost of care. The commissioner may collect all third-party payments for chemical dependency services provided under Laws 1986, chapter 394, sections 8 to 20, including private insurance and federal Medicaid and Medicare financial participation. ~~The commissioner shall deposit in a dedicated account a percentage of collections to pay for the cost of operating the chemical dependency consolidated treatment fund invoice processing and vendor payment system, billing, and collections.~~ The remaining receipts must be deposited in the chemical dependency fund.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 14. Minnesota Statutes 2018, section 254B.06, subdivision 2, is amended to read:

Subd. 2. **Allocation of collections.** ~~(a) The commissioner shall allocate all federal financial participation collections to a special revenue account.~~ The commissioner shall allocate 77.05 percent of patient payments and third-party payments to the special revenue account and 22.95 percent to the county financially responsible for the patient.

~~(b) For fiscal year 2017 only, the commissioner's allocation to the special revenue account shall be increased from 77.05 percent to 79.8 percent and the county financial responsibility shall be reduced from 22.95 percent to 20.2 percent.~~

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 15. Minnesota Statutes 2018, section 256.478, is amended to read:

**256.478 ~~HOME AND COMMUNITY-BASED SERVICES TRANSITIONS GRANTS~~ TRANSITION TO COMMUNITY INITIATIVE.**

Subdivision 1. **Eligibility.** (a) An individual is eligible for the transition to community initiative if the individual meets the following criteria:

(1) without the additional resources available through the transitions to community initiative the individual would otherwise remain at the Anoka-Metro Regional Treatment Center, a state-operated community behavioral health hospital, or the Minnesota Security Hospital;

(2) the individual's discharge would be significantly delayed without the additional resources available through the transitions to community initiative; and

(3) the individual met treatment objectives and no longer needs hospital-level care or a secure treatment setting.

(b) An individual who is in a community hospital and on the waiting list for the Anoka-Metro Regional Treatment Center, but for whom alternative community placement would be appropriate is eligible for the transition to community initiative upon the commissioner's approval.

Subd. 2. **Transition grants.** The commissioner shall make available ~~home and community-based services~~ transition to community grants to ~~serve~~ assist individuals ~~who do not meet eligibility criteria for the medical assistance program under section 256B.056 or 256B.057, but who otherwise meet the criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24~~ who met the criteria under subdivision 1.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 16. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers certified community behavioral health clinic (CCBHC) services that meet the requirements of section 245.735, subdivision 3.

(b) The commissioner shall establish standards and methodologies for a prospective payment system for medical assistance payments for services delivered by a CCBHC, in

accordance with guidance issued by the Centers for Medicare and Medicaid Services. The commissioner shall include a quality bonus payment in the prospective payment system based on federal criteria.

(c) To the extent allowed by federal law, the commissioner may limit the number of CCBHCs for the prospective payment system in paragraph (b) to ensure that the projected claims do not exceed the money appropriated for this purpose. The commissioner shall apply the following priorities, in the order listed, to give preference to clinics that:

(1) provide a comprehensive range of services and evidence-based practices for all age groups, with services being fully coordinated and integrated;

(2) are certified as CCBHCs during the federal CCBHC demonstration period;

(3) receive CCBHC grants from the United States Department of Health and Human Services; or

(4) focus on serving individuals in tribal areas and other underserved communities.

(d) Unless otherwise indicated in applicable federal requirements, the prospective payment system must continue to be based on the federal instructions issued for the federal CCBHC demonstration, except:

(1) the commissioner shall rebase CCBHC rates at least every three years;

(2) the commissioner shall provide for a 60-day appeals process of the rebasing;

(3) the prohibition against inclusion of new facilities in the demonstration does not apply after the demonstration ends;

(4) the prospective payment rate under this section does not apply to services rendered by CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service. An entity that receives a prospective payment system rate that overlaps with the CCBHC rate is not eligible for the CCBHC rate;

(5) payments for CCBHC services to individuals enrolled in managed care shall be coordinated with the state's phase-out of CCBHC wrap payments;

(6) initial prospective payment rates for CCBHCs certified after July 1, 2019, shall be based on rates for comparable CCBHCs. If no comparable provider exists, the commissioner shall compute a CCBHC-specific rate based upon the CCBHC's audited costs adjusted for changes in the scope of services; and

(7) the prospective payment rate for each CCBHC shall be adjusted annually by the Medicare Economic Index as defined for the CCBHC federal demonstration.

**EFFECTIVE DATE.** Contingent upon federal approval, this section is effective July 1, 2019. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained or denied.

Sec. 17. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 20c. **Integrated care model; mental health case management services by Center for Victims of Torture.** (a) The commissioner of human services, in collaboration with the Center for Victims of Torture, shall develop a pilot project to support the continued testing of an integrated care model for the delivery of mental health targeted case management at one designated service site. For purposes of this subdivision, "center" means the Center for Victims of Torture.

(b) The commissioner of human services shall contract directly with the center for the provision of the services described in paragraph (c). The services shall be paid at $695 per member per month and shall be funded using 100 percent state funding.

(c) Individuals who are eligible to receive medical assistance under this chapter, who are eligible to receive mental health targeted case management as described under section 245.4711, and who are being served by the center shall be served using the integrated care model and must be evaluated using the center's social functioning tool.

(d) The commissioner of human services, in collaboration with the center, shall also evaluate whether the center's social functioning tool can be adapted for use with the general medical assistance population. Beginning July 1, 2020, and annually thereafter until the evaluation is complete, the commissioner of human services shall report on the results of the evaluation to the legislative committees with jurisdiction over human services.

Sec. 18. Minnesota Statutes 2018, section 256B.0625, subdivision 24, is amended to read:

Subd. 24. **Other medical or remedial care.** Medical assistance covers any other medical or remedial care licensed and recognized under state law unless otherwise prohibited by law~~, except licensed chemical dependency treatment programs or primary treatment or extended care treatment units in hospitals that are covered under chapter 254B. The commissioner shall include chemical dependency services in the state medical assistance plan for federal reporting purposes, but payment must be made under chapter 254B~~. The commissioner shall publish in the State Register a list of elective surgeries that require a second medical opinion before medical assistance reimbursement, and the criteria and standards for deciding whether an elective surgery should require a second medical opinion.

The list and criteria and standards are not subject to the requirements of sections 14.01 to 14.69.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 19. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 24a. **Substance use disorder services.** Medical assistance covers substance use disorder treatment services according to section 254B.05, subdivision 5, except for room and board.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 20. Minnesota Statutes 2018, section 256B.0625, subdivision 45a, is amended to read:

Subd. 45a. **Psychiatric residential treatment facility services for persons younger than 21 years of age.** (a) Medical assistance covers psychiatric residential treatment facility services, according to section 256B.0941, for persons younger than 21 years of age. Individuals who reach age 21 at the time they are receiving services are eligible to continue receiving services until they no longer require services or until they reach age 22, whichever occurs first.

(b) For purposes of this subdivision, "psychiatric residential treatment facility" means a facility other than a hospital that provides psychiatric services, as described in Code of Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under age 21 in an inpatient setting.

(c) The commissioner shall enroll up to 150 certified psychiatric residential treatment facility services beds ~~at up to six sites~~. The commissioner may enroll an additional 80 certified psychiatric residential treatment facility services beds beginning July 1, 2020, and an additional 70 certified psychiatric residential treatment facility services beds beginning July 1, 2023. The commissioner shall select psychiatric residential treatment facility services providers through a request for proposals process. Providers of state-operated services may respond to the request for proposals. The commissioner shall prioritize programs that demonstrate the capacity to serve children and youth with aggressive and risky behaviors toward themselves or others, multiple diagnoses, neurodevelopmental disorders, or complex trauma related issues.

(d) Notwithstanding the limit on the number of certified psychiatric residential treatment facility services beds under paragraph (c), providers of children's residential treatment under section 256B.0945, who are enrolled to provide services as of July 1, 2019, may submit a letter of intent to develop a psychiatric residential treatment facility program in a format developed by the commissioner. Each letter of intent must demonstrate the need for psychiatric residential treatment facility services, the proposed bed capacity for the program, and the capacity of the organization to develop and deliver psychiatric residential treatment facility services. The letter of intent must also include a description of the proposed services and physical site as well as specific information about the population that the program plans to serve. The commissioner shall respond to the letter of intent within 60 days of receiving all requested information with a determination of whether the program is approved, or with specific recommended actions required to obtain approval. Programs that receive an approved letter of intent must initiate the processes required by the commissioner to enroll as a provider of psychiatric residential treatment facility services within 30 days of receiving notice of approval. The commissioner shall process letters of intent in the order received. A program approved under this paragraph may not increase bed capacity when converting to provide psychiatric residential treatment facility services.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 21. Minnesota Statutes 2018, section 256B.0625, subdivision 57, is amended to read:

Subd. 57. **Payment for Part B Medicare crossover claims.** (a) Effective for services provided on or after January 1, 2012, medical assistance payment for an enrollee's cost-sharing associated with Medicare Part B is limited to an amount up to the medical assistance total allowed, when the medical assistance rate exceeds the amount paid by Medicare.

(b) Excluded from this limitation are payments for mental health services and payments for dialysis services provided to end-stage renal disease patients. The exclusion for mental health services does not apply to payments for physician services provided by psychiatrists and advanced practice nurses with a specialty in mental health.

(c) Excluded from this limitation are payments to federally qualified health centers ~~and~~, rural health clinics, and CCBHCs subject to the prospective payment system under subdivision 5m.

**EFFECTIVE DATE.** Contingent upon federal approval, this section is effective July 1, 2019. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained or denied.

Sec. 22. Minnesota Statutes 2018, section 256B.0757, subdivision 2, is amended to read:

Subd. 2. **Eligible individual.** (a) The commissioner may develop health home models in accordance with United States Code, title 42, section 1396w-4(h)(1).

(b) An individual is eligible for health home services under this section if the individual is eligible for medical assistance under this chapter and ~~has at least:~~

~~(1) two chronic conditions;~~

~~(2) one chronic condition and is at risk of having a second chronic condition;~~

~~(3) one serious and persistent mental health condition; or~~

~~(4)~~ has a condition that meets the definition of serious mental illness as described in section 245.462, subdivision 20, paragraph (a), or emotional disturbance as defined in section 245.4871, subdivision 15, clause (2)~~; and has a current diagnostic assessment as defined in Minnesota Rules, part 9505.0372, subpart 1, item B or C, as performed or reviewed by a mental health professional employed by or under contract with the behavioral health home~~.

The commissioner shall establish criteria for determining continued eligibility.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 23. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 2a. **Discharge criteria.** (a) An individual may be discharged from behavioral health home services if:

(1) the behavioral health home services provider is unable to locate, contact, and engage the individual for a period of greater than three months after persistent efforts by the behavioral health home services provider; or

(2) the individual is unwilling to participate in behavioral health home services as demonstrated by the individual's refusal to meet with the behavioral health home services provider, or refusal to identify the individual's health and wellness goals or the activities or support necessary to achieve these goals.

(b) Before discharge from behavioral health home services, the behavioral health home services provider must offer a face-to-face meeting with the individual and the individual's identified supports, to discuss options available to the individual, including maintaining behavioral health home services.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 24. Minnesota Statutes 2018, section 256B.0757, subdivision 4, is amended to read:

Subd. 4. **Designated provider.** ~~(a)~~ Health home services are voluntary and an eligible individual may choose any designated provider. The commissioner shall establish designated providers to serve as health homes and provide the services described in subdivision 3 to individuals eligible under subdivision 2. The commissioner shall apply for grants as provided under section 3502 of the Patient Protection and Affordable Care Act to establish health homes and provide capitated payments to designated providers. For purposes of this section, "designated provider" means a provider, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, or any other entity that is determined by the commissioner to be qualified to be a health home for eligible individuals. This determination must be based on documentation evidencing that the designated provider has the systems and infrastructure in place to provide health home services and satisfies the qualification standards established by the commissioner in consultation with stakeholders and approved by the Centers for Medicare and Medicaid Services.

~~(b) The commissioner shall develop and implement certification standards for designated providers under this subdivision.~~

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 25. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 4a. **Behavioral health home services provider requirements.** A behavioral health home services provider must:

(1) be an enrolled Minnesota Health Care Programs provider;

(2) provide a medical assistance covered primary care or behavioral health service;

(3) utilize an electronic health record;

(4) utilize an electronic patient registry that contains the data elements required by the commissioner;

(5) demonstrate the organization's capacity to administer screenings approved by the commissioner for substance use disorder or alcohol and tobacco use;

(6) demonstrate the organization's capacity to refer an individual to resources appropriate to the individual's screening results;

(7) have policies and procedures to track referrals to ensure that the referral met the individual's needs;

(8) conduct a brief needs assessment when an individual begins receiving behavioral health home services. The brief needs assessment must be completed with input from the individual and the individual's identified supports. The brief needs assessment must address the individual's immediate safety and transportation needs and potential barriers to participating in behavioral health home services;

(9) conduct a health wellness assessment within 60 days after intake that contains all required elements identified by the commissioner;

(10) conduct a health action plan that contains all required elements identified by the commissioner. The plan must be completed within 90 days after intake and must be updated at least once every six months, or more frequently if significant changes to an individual's needs or goals occur;

(11) agree to cooperate with and participate in the state's monitoring and evaluation of behavioral health home services; and

(12) obtain the individual's written consent to begin receiving behavioral health home services using a form approved by the commissioner.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 26. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 4b. **Behavioral health home provider training and practice transformation requirements.** (a) The behavioral health home services provider must ensure that all staff delivering behavioral health home services receive adequate preservice and ongoing training, including:

(1) training approved by the commissioner that describes the goals and principles of behavioral health home services; and

(2) training on evidence-based practices to promote an individual's ability to successfully engage with medical, behavioral health, and social services to achieve the individual's health and wellness goals.

(b) The behavioral health home services provider must ensure that staff are capable of implementing culturally responsive services, as determined by the individual's culture, beliefs, values, and language as identified in the individual's health wellness assessment.

(c) The behavioral health home services provider must participate in the department's practice transformation activities to support continued skill and competency development in the provision of integrated medical, behavioral health, and social services.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 27. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 4c. **Behavioral health home staff qualifications.** (a) A behavioral health home services provider must maintain staff with required professional qualifications appropriate to the setting.

(b) If behavioral health home services are offered in a mental health setting, the integration specialist must be a registered nurse licensed under the Minnesota Nurse Practice Act, sections 148.171 to 148.285.

(c) If behavioral health home services are offered in a primary care setting, the integration specialist must be a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6).

(d) If behavioral health home services are offered in either a primary care setting or mental health setting, the systems navigator must be a mental health practitioner as defined in section 245.462, subdivision 17, or a community health worker as defined in section 256B.0625, subdivision 49.

(e) If behavioral health home services are offered in either a primary care setting or mental health setting, the qualified health home specialist must be one of the following:

(1) a peer support specialist as defined in section 256B.0615;

(2) a family peer support specialist as defined in section 256B.0616;

(3) a case management associate as defined in section 245.462, subdivision 4, paragraph (g), or 245.4871, subdivision 4, paragraph (j);

(4) a mental health rehabilitation worker as defined in section 256B.0623, subdivision 5, clause (4);

(5) a community paramedic as defined in section 144E.28, subdivision 9;

(6) a peer recovery specialist as defined in section 245G.07, subdivision 1, clause (5); or

(7) a community health worker as defined in section 256B.0625, subdivision 49.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 28. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 4d. **Behavioral health home service delivery standards.** (a) A behavioral health home services provider must meet the following service delivery standards:

(1) establish and maintain processes to support the coordination of an individual's primary care, behavioral health, and dental care;

(2) maintain a team-based model of care, including regular coordination and communication between behavioral health home services team members;

(3) use evidence-based practices that recognize and are tailored to the medical, social, economic, behavioral health, functional impairment, cultural, and environmental factors affecting the individual's health and health care choices;

(4) use person-centered planning practices to ensure the individual's health action plan accurately reflects the individual's preferences, goals, resources, and optimal outcomes for the individual and the individual's identified supports;

(5) use the patient registry to identify individuals and population subgroups requiring specific levels or types of care and provide or refer the individual to needed treatment, intervention, or services;

(6) utilize the Department of Human Services Partner Portal to identify past and current treatment or services and identify potential gaps in care;

(7) deliver services consistent with the standards for frequency and face-to-face contact required by the commissioner;

(8) ensure that a diagnostic assessment is completed for each individual receiving behavioral health home services within six months of the start of behavioral health home services;

(9) deliver services in locations and settings that meet the needs of the individual;

(10) provide a central point of contact to ensure that individuals and the individual's identified supports can successfully navigate the array of services that impact the individual's health and well-being;

(11) have capacity to assess an individual's readiness for change and the individual's capacity to integrate new health care or community supports into the individual's life;

(12) offer or facilitate the provision of wellness and prevention education on evidenced-based curriculums specific to the prevention and management of common chronic conditions;

(13) help an individual set up and prepare for medical, behavioral health, social service, or community support appointments, including accompanying the individual to appointments as appropriate, and providing follow-up with the individual after these appointments;

(14) offer or facilitate the provision of health coaching related to chronic disease management and the navigation of complex systems of care to the individual, the individual's family, and identified supports;

(15) connect the individual, the individual's family, and identified supports to appropriate support services that help the individual overcome access or service barriers, increase self-sufficiency skills, and improve overall health;

(16) provide effective referrals and timely access to services; and

(17) establish a continuous quality improvement process for providing behavioral health home services.

(b) The behavioral health home services provider must also create a plan, in partnership with the individual and the individual's identified supports, to support the individual after discharge from a hospital, residential treatment program, or other setting. The plan must include protocols for:

(1) maintaining contact between the behavioral health home services team member, the individual, and the individual's identified supports during and after discharge;

(2) linking the individual to new resources as needed;

(3) reestablishing the individual's existing services and community and social supports; and

(4) following up with appropriate entities to transfer or obtain the individual's service records as necessary for continued care.

(c) If the individual is enrolled in a managed care plan, a behavioral health home services provider must:

(1) notify the behavioral health home services contact designated by the managed care plan within 30 days of when the individual begins behavioral health home services; and

(2) adhere to the managed care plan communication and coordination requirements described in the behavioral health home services manual.

(d) Before terminating behavioral health home services, the behavioral health home services provider must:

(1) provide a 60-day notice of termination of behavioral health home services to all individuals receiving behavioral health home services, the commissioner, and managed care plans, if applicable; and

(2) refer individuals receiving behavioral health home services to a new behavioral health home services provider.

Sec. 29. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 4e. **Behavioral health home provider variances.** (a) The commissioner may grant a variance to specific requirements under subdivisions 4a, 4b, 4c, or 4d for a behavioral health home services provider according to this subdivision.

(b) The commissioner may grant a variance if the commissioner finds that:

(1) failure to grant the variance would result in hardship or injustice to the applicant;

(2) the variance would be consistent with the public interest; and

(3) the variance would not reduce the level of services provided to individuals served by the organization.

(c) The commissioner may grant a variance from one or more requirements to permit an applicant to offer behavioral health home services of a type or in a manner that is innovative, if the commissioner finds that the variance does not impede the achievement of the criteria in subdivisions 4a, 4b, 4c, or 4d and may improve the behavioral health home services provided by the applicant.

(d) The commissioner's decision to grant or deny a variance request is final and not subject to appeal.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 30. Minnesota Statutes 2018, section 256B.0757, subdivision 8, is amended to read:

Subd. 8. **Evaluation and continued development.** (a) For continued certification under this section, behavioral health homes must meet process, outcome, and quality standards developed and specified by the commissioner. The commissioner shall collect data from health homes as necessary to monitor compliance with certification standards.

(b) The commissioner may contract with a private entity to evaluate patient and family experiences, health care utilization, and costs.

(c) The commissioner shall utilize findings from the implementation of ~~behavioral~~ health homes to determine populations to serve under subsequent health home models for individuals with chronic conditions.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 31. **[256B.0759] SUBSTANCE USE DISORDER DEMONSTRATION PROJECT.**

Subdivision 1. **Establishment.** The commissioner shall develop and implement a medical assistance demonstration project to test reforms of Minnesota's substance use disorder treatment system to ensure individuals with substance use disorders have access to a full continuum of high quality care.

Subd. 2. **Provider participation.** Substance use disorder treatment providers may elect to participate in the demonstration project and meet the requirements of subdivision 3. To participate, a provider must notify the commissioner of the provider's intent to participate in a format required by the commissioner and enroll as a demonstration project provider.

Subd. 3. **Provider standards.** (a) The commissioner shall establish requirements for participating providers that are consistent with the federal requirements of the demonstration project.

(b) A participating residential provider must obtain applicable licensure under chapters 245F and 245G or other applicable standards for the services provided and must:

(1) deliver services in accordance with American Society of Addiction Medicine (ASAM) standards;

(2) maintain formal patient referral arrangements with providers delivering step-up or step-down levels of care in accordance with ASAM standards; and

(3) provide or arrange for medication-assisted treatment services if requested by a client for whom an effective medication exists.

(c) A participating outpatient provider must obtain applicable licensure under chapter 245G or other applicable standards for the services provided and must:

(1) deliver services in accordance with ASAM standards; and

(2) maintain formal patient referral arrangements with providers delivering step-up or step-down levels of care in accordance with ASAM standards.

(d) If the provider standards under chapter 245G or other applicable standards conflict or are duplicative, the commissioner may grant variances to the standards if the variances do not conflict with federal requirements. The commissioner shall publish service components, service standards, and staffing requirements for participating providers that are consistent with ASAM standards and federal requirements.

Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must be increased for services provided to medical assistance enrollees.

(b) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clause (8), payment rates must be increased by 15 percent over the rates in effect on January 1, 2020.

(c) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clauses (1), (6), (7), and (10), payment rates must be increased by ten percent over the rates in effect on January 1, 2021.

Subd. 5. **Federal approval.** The commissioner shall seek federal approval to implement the demonstration project under this section and to receive federal financial participation.

Sec. 32. Minnesota Statutes 2018, section 256B.0915, subdivision 3b, is amended to read:

Subd. 3b. **Cost limits for elderly waiver applicants who reside in a nursing facility or another eligible facility.** (a) For a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly waivered services, a monthly conversion budget limit for the cost of elderly waivered services may be requested. The monthly conversion budget limit for the cost of elderly waiver services shall be ~~the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides until July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented, the monthly conversion budget limit for the cost of elderly waiver services shall be~~ based on the per diem nursing facility rate as determined by the resident assessment system as described in section ~~256B.438~~ 256R.17 for residents in the nursing facility where the elderly waiver applicant currently resides. The monthly conversion budget limit shall be calculated by multiplying the per diem by 365, divided by 12, and reduced by the recipient's maintenance needs allowance as described in subdivision 1d. The initially approved monthly conversion budget limit shall be adjusted annually as described in subdivision 3a, paragraph (a). The limit under this ~~subdivision~~ paragraph only applies to

persons discharged from a nursing facility after a minimum 30-day stay and found eligible for waivered services on or after July 1, 1997. For conversions from the nursing home to the elderly waiver with consumer directed community support services, the nursing facility per diem used to calculate the monthly conversion budget limit must be reduced by a percentage equal to the percentage difference between the consumer directed services budget limit that would be assigned according to the federally approved waiver plan and the corresponding community case mix cap, but not to exceed 50 percent.

(b) A person who meets elderly waiver eligibility criteria and the eligibility criteria under section 256.478, subdivision 1, is eligible for a special monthly budget limit for the cost of elderly waivered services up to $21,610 per month. The special monthly budget limit must be adjusted annually as described in subdivision 3a, paragraphs (a) and (e). For a person using a special monthly budget limit under the elderly waiver with consumer-directed community support services, the special monthly budget limit must be reduced as described in paragraph (a).

(c) The commissioner may provide an additional payment for documented costs between a threshold determined by the commissioner and the special monthly budget limit to a managed care plan for elderly waiver services provided to a person who is: (1) eligible for a special monthly budget limit under paragraph (b); and (2) enrolled in a managed care plan that provides elderly waiver services under section 256B.69.

(d) For monthly conversion budget limits under paragraph (a) and special monthly budget limits under paragraph (b), the service rate limits for adult foster care under subdivision 3d and for customized living under subdivision 3e may be exceeded if necessary for the provider to meet identified needs and provide services as approved in the coordinated service and support plan, if the total cost of all services does not exceed the monthly conversion or special monthly budget limit. Service rates must be established using tools provided by the commissioner.

(e) The following costs must be included in determining the total monthly costs for the waiver client:

(1) cost of all waivered services, including specialized supplies and equipment and environmental accessibility adaptations; and

(2) cost of skilled nursing, home health aide, and personal care services reimbursable by medical assistance.

**EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes once federal approval is obtained.

Sec. 33. Minnesota Statutes 2018, section 256B.092, subdivision 13, is amended to read:

Subd. 13. **Waiver allocations for transition populations.** (a) The commissioner shall make available additional waiver allocations and additional necessary resources ~~to assure timely discharges from the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital in St. Peter~~ for individuals who meet the ~~following~~ eligibility criteria~~:~~ established under section 256.478, subdivision 1.

~~(1) are otherwise eligible for the developmental disabilities waiver under this section;~~

~~(2) who would otherwise remain at the Anoka-Metro Regional Treatment Center or the Minnesota Security Hospital;~~

~~(3) whose discharge would be significantly delayed without the available waiver allocation; and~~

~~(4) who have met treatment objectives and no longer meet hospital level of care.~~

(b) Additional waiver allocations under this subdivision must meet cost-effectiveness requirements of the federal approved waiver plan.

(c) Any corporate foster care home developed under this subdivision must be considered an exception under section 245A.03, subdivision 7, paragraph (a).

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 34. Minnesota Statutes 2018, section 256B.0941, subdivision 3, is amended to read:

Subd. 3. **Per diem rate.** (a) The commissioner shall establish ~~a statewide~~ one per diem rate per provider for psychiatric residential treatment facility services for individuals 21 years of age or younger. The rate for a provider must not exceed the rate charged by that provider for the same service to other payers. Payment must not be made to more than one entity for each individual for services provided under this section on a given day. The commissioner shall set rates prospectively for the annual rate period. The commissioner shall require providers to submit annual cost reports on a uniform cost reporting form and shall use submitted cost reports to inform the rate-setting process. The cost reporting shall be done according to federal requirements for Medicare cost reports.

(b) The following are included in the rate:

(1) costs necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care, and discharge planning. The direct services costs must be determined

using the actual cost of salaries, benefits, payroll taxes, and training of direct services staff and service-related transportation; and

(2) payment for room and board provided by facilities meeting all accreditation and licensing requirements for participation.

(c) A facility may submit a claim for payment outside of the per diem for professional services arranged by and provided at the facility by an appropriately licensed professional who is enrolled as a provider with Minnesota health care programs. Arranged services must be billed by the facility on a separate claim, and the facility shall be responsible for payment to the provider. These services must be included in the individual plan of care and are subject to prior authorization by the state's medical review agent.

(d) Medicaid shall reimburse for concurrent services as approved by the commissioner to support continuity of care and successful discharge from the facility. "Concurrent services" means services provided by another entity or provider while the individual is admitted to a psychiatric residential treatment facility. Payment for concurrent services may be limited and these services are subject to prior authorization by the state's medical review agent. Concurrent services may include targeted case management, assertive community treatment, clinical care consultation, team consultation, and treatment planning.

(e) Payment rates under this subdivision shall not include the costs of providing the following services:

(1) educational services;

(2) acute medical care or specialty services for other medical conditions;

(3) dental services; and

(4) pharmacy drug costs.

(f) For purposes of this section, "actual cost" means costs that are allowable, allocable, reasonable, and consistent with federal reimbursement requirements in Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and the Office of Management and Budget Circular Number A-122, relating to nonprofit entities.

Sec. 35. Minnesota Statutes 2018, section 256B.49, subdivision 24, is amended to read:

Subd. 24. **Waiver allocations for transition populations.** (a) The commissioner shall make available additional waiver allocations and additional necessary resources ~~to assure timely discharges from the Anoka-Metro Regional Treatment Center and the Minnesota~~

~~Security Hospital in St. Peter~~ for individuals who meet the ~~following~~ eligibility criteria~~:~~ established under section 256.478, subdivision 1.

~~(1) are otherwise eligible for the brain injury, community access for disability inclusion, or community alternative care waivers under this section;~~

~~(2) who would otherwise remain at the Anoka-Metro Regional Treatment Center or the Minnesota Security Hospital;~~

~~(3) whose discharge would be significantly delayed without the available waiver allocation; and~~

~~(4) who have met treatment objectives and no longer meet hospital level of care.~~

(b) Additional waiver allocations under this subdivision must meet cost-effectiveness requirements of the federal approved waiver plan.

(c) Any corporate foster care home developed under this subdivision must be considered an exception under section 245A.03, subdivision 7, paragraph (a).

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 36. Minnesota Statutes 2018, section 256I.04, subdivision 1, is amended to read:

Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and entitled to a housing support payment to be made on the individual's behalf if the agency has approved the setting where the individual will receive housing support and the individual meets the requirements in paragraph (a), (b), or (c).

(a) The individual is aged, blind, or is over 18 years of age with a disability as determined under the criteria used by the title II program of the Social Security Act, and meets the resource restrictions and standards of section 256P.02, and the individual's countable income after deducting the (1) exclusions and disregards of the SSI program, (2) the medical assistance personal needs allowance under section 256B.35, and (3) an amount equal to the income actually made available to a community spouse by an elderly waiver participant under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058, subdivision 2, is less than the monthly rate specified in the agency's agreement with the provider of housing support in which the individual resides.

(b) The individual meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), clauses (1), (3), (4) to (8), and (13), and paragraph (b), if applicable, and the individual's resources are less than the standards specified by section 256P.02, and the individual's countable income as determined under section 256P.06, less the medical

assistance personal needs allowance under section 256B.35 is less than the monthly rate specified in the agency's agreement with the provider of housing support in which the individual resides.

(c) The individual ~~receives licensed residential crisis stabilization services under section 256B.0624, subdivision 7, and is receiving medical assistance. The individual may receive concurrent housing support payments if receiving licensed residential crisis stabilization services under section 256B.0624, subdivision 7.~~ lacks a fixed, adequate, nighttime residence upon discharge from a residential behavioral health treatment program, as determined by treatment staff from the residential behavioral health treatment program. An individual is eligible under this paragraph for up to three months, including a full or partial month from the individual's move-in date at a setting approved for housing support following discharge from treatment, plus two full months.

**EFFECTIVE DATE.** This section is effective September 1, 2019.

Sec. 37. Minnesota Statutes 2018, section 256I.04, subdivision 2f, is amended to read:

Subd. 2f. **Required services.** (a) In licensed and registered settings under subdivision 2a, providers shall ensure that participants have at a minimum:

(1) food preparation and service for three nutritional meals a day on site;

(2) a bed, clothing storage, linen, bedding, laundering, and laundry supplies or service;

(3) housekeeping, including cleaning and lavatory supplies or service; and

(4) maintenance and operation of the building and grounds, including heat, water, garbage removal, electricity, telephone for the site, cooling, supplies, and parts and tools to repair and maintain equipment and facilities.

(b) In addition, when providers serve participants described in subdivision 1, paragraph (c), the providers are required to assist the participants in applying for continuing housing support payments before the end of the eligibility period.

**EFFECTIVE DATE.** This section is effective September 1, 2019.

Sec. 38. Minnesota Statutes 2018, section 256I.06, subdivision 8, is amended to read:

Subd. 8. **Amount of housing support payment.** (a) The amount of a room and board payment to be made on behalf of an eligible individual is determined by subtracting the individual's countable income under section 256I.04, subdivision 1, for a whole calendar month from the room and board rate for that same month. The housing support payment is

determined by multiplying the housing support rate times the period of time the individual was a resident or temporarily absent under section 256I.05, subdivision 1c, paragraph (d).

(b) For an individual with earned income under paragraph (a), prospective budgeting must be used to determine the amount of the individual's payment for the following six-month period. An increase in income shall not affect an individual's eligibility or payment amount until the month following the reporting month. A decrease in income shall be effective the first day of the month after the month in which the decrease is reported.

(c) For an individual who receives ~~licensed residential crisis stabilization services under section 256B.0624, subdivision 7,~~ housing support payments under section 256I.04, subdivision 1, paragraph (c), the amount of the housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident.

**EFFECTIVE DATE.** This section is effective September 1, 2019.

Sec. 39. Minnesota Statutes 2018, section 641.15, subdivision 3a, is amended to read:

Subd. 3a. **Intake procedure; approved mental health screening.** (a) As part of its intake procedure for new ~~prisoners~~ inmates, the sheriff or local corrections shall use a mental health screening tool approved by the commissioner of corrections in consultation with the commissioner of human services and local corrections staff to identify persons who may have mental illness.

(b) Names of persons who have screened positive or may have a mental illness may be shared with the local county social services agency. The jail may refer an offender to county personnel of the welfare system, as defined in section 13.46, subdivision 1, paragraph (c), in order to arrange for services upon discharge and may share private data on the offender as necessary to:

(1) provide assistance in filling out an application for medical assistance or MinnesotaCare;

(2) make a referral for case management as provided under section 245.467, subdivision 4;

(3) provide assistance in obtaining a state photo identification;

(4) secure a timely appointment with a psychiatrist or other appropriate community mental health provider;

(5) provide prescriptions for a 30-day supply of all necessary medications; or

(6) coordinate behavioral health services.

(c) Notwithstanding section 138.17, if an offender is referred to a government entity within the welfare system pursuant to paragraph (b), and the offender refuses all services from the entity, the entity must, within 15 days of the refusal, destroy all private data on the offender that it created or received because of the referral.

Sec. 40. Laws 2017, First Special Session chapter 6, article 8, section 71, the effective date, is amended to read:

**EFFECTIVE DATE.** This section is effective for services provided on July 1, 2017, ~~through April 30, 2019, and expires May 1, 2019~~ and thereafter.

**EFFECTIVE DATE.** This section is effective April 30, 2019.

Sec. 41. Laws 2017, First Special Session chapter 6, article 8, section 72, the effective date, is amended to read:

**EFFECTIVE DATE.** This section is effective for services provided on July 1, 2017, ~~through April 30, 2019, and expires May 1, 2019~~ and thereafter.

**EFFECTIVE DATE.** This section is effective April 30, 2019.

Sec. 42. **COMMUNITY COMPETENCY RESTORATION TASK FORCE.**

Subdivision 1. **Establishment; purpose.** The Community Competency Restoration Task Force is established to evaluate and study community competency restoration programs and develop recommendations to address the needs of individuals deemed incompetent to stand trial.

Subd. 2. **Membership.** (a) The Community Competency Restoration Task Force consists of the following members, appointed as follows:

(1) a representative appointed by the governor's office;

(2) the commissioner of human services or designee;

(3) the commissioner of corrections or designee;

(4) a representative from direct care and treatment services with experience in competency evaluations, appointed by the commissioner of human services;

(5) a representative appointed by the designated State Protection and Advocacy system;

(6) the ombudsman for mental health and developmental disabilities;

(7) a representative appointed by the Minnesota Hospital Association;

(8) a representative appointed by the Association of Minnesota Counties;

(9) three representatives appointed by the Minnesota Association of County Social Service Administrators: one from the seven-county metropolitan area, as defined under Minnesota Statutes, section 473.121, subdivision 2, and two from outside the seven-county metropolitan area;

(10) a representative appointed by the Minnesota Board of Public Defense;

(11) two representatives appointed by the Minnesota County Attorneys Association;

(12) a representative appointed by the Minnesota Chiefs of Police Association;

(13) a representative appointed by the Minnesota Psychiatric Society;

(14) a representative appointed by the Minnesota Psychological Association;

(15) a representative appointed by the State Court Administrator;

(16) a representative appointed by the Minnesota Association of Community Mental Health Programs;

(17) a representative appointed by the Minnesota Sheriffs' Association;

(18) a representative appointed by the Minnesota Sentencing Guidelines Commission;

(19) a jail administrator appointed by the Minnesota Sheriffs' Association;

(20) a representative from an organization providing reentry services appointed by the commissioner of corrections;

(21) a representative from a mental health advocacy organization appointed by the commissioner of human services;

(22) a person with direct experience with competency restoration appointed by the commissioner of human services;

(23) representatives from organizations representing racial and ethnic groups overrepresented in the justice system appointed by the commissioner of corrections;

(24) a representative appointed by the Minnesota Assistance Council for Veterans; and

(25) a crime victim appointed by the commissioner of corrections.

(b) Appointments to the task force must be made no later than July 15, 2019, and members of the task force may be compensated as provided under Minnesota Statutes, section 15.059, subdivision 3.

Subd. 3. **Duties.** The task force must:

(1) identify current services and resources available for individuals in the criminal justice system who have been found incompetent to stand trial;

(2) analyze current trends of competency referrals by county and the impact of any diversion projects or stepping-up initiatives;

(3) analyze selected case reviews and other data to identify risk levels of those individuals, service usage, housing status, and health insurance status prior to being jailed;

(4) research how other states address this issue, including funding and structure of community competency restoration programs, and jail-based programs; and

(5) develop recommendations to address the growing number of individuals deemed incompetent to stand trial including increasing prevention and diversion efforts, providing a timely process for reducing the amount of time individuals remain in the criminal justice system, determining how to provide and fund competency restoration services in the community, and defining the role of the counties and state in providing competency restoration.

Subd. 4. **Officers; meetings.** (a) The commissioner of human services shall convene the first meeting of the task force no later than August 1, 2019.

(b) The task force must elect a chair and vice-chair from among its members and may elect other officers as necessary.

(c) The task force is subject to the Minnesota Open Meeting Law under Minnesota Statutes, chapter 13D.

Subd. 5. **Staff.** (a) The commissioner of human services must provide staff assistance to support the task force's work.

(b) The task force may utilize the expertise of the Council of State Governments Justice Center.

Subd. 6. **Report required.** (a) By February 1, 2020, the task force shall submit a report on its progress and findings to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health and corrections.

(b) By February 1, 2021, the task force must submit a written report including recommendations to address the growing number of individuals deemed incompetent to stand trial to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health and corrections.

Subd. 7. **Expiration.** The task force expires upon submission of the report in subdivision 6, paragraph (b), or February 1, 2021, whichever is later.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 43. **DIRECTION TO COMMISSIONER; IMPROVING SCHOOL-LINKED MENTAL HEALTH GRANT PROGRAM.**

(a) The commissioner of human services, in collaboration with the commissioner of education, representatives from the education community, mental health providers, and advocates, shall assess the school-linked mental health grant program under Minnesota Statutes, section 245.4901, and develop recommendations for improvements. The assessment must include but is not limited to the following:

(1) promoting stability among current grantees and school partners;

(2) assessing the minimum number of full-time equivalents needed per school site to effectively carry out the program;

(3) developing a funding formula that promotes sustainability and consistency across grant cycles;

(4) reviewing current data collection and evaluation; and

(5) analyzing the impact on outcomes when a school has a school-linked mental health program, a multi-tier system of supports, and sufficient school support personnel to meet the needs of students.

(b) The commissioner shall provide a report of the findings of the assessment and recommendations, including any necessary statutory changes, to the legislative committees with jurisdiction over mental health and education by January 15, 2020.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 44. **DIRECTION TO COMMISSIONER; CCBHC RATE METHODOLOGY.**

(a) The commissioner of human services shall develop recommendations for a rate methodology that reflects each CCBHC's reasonable cost of providing the services described in Minnesota Statutes, section 245.735, subdivision 3, consistent with applicable federal requirements. In developing the rate methodology, the commissioner shall consider guidance issued by the Centers for Medicare and Medicaid Services for the Section 223 Demonstration Program for CCBHC and costs associated with the following:

(1) a new CCBHC service that is not incorporated in the baseline prospective payment system rate, or a deletion of a CCBHC service that is incorporated in the baseline rate;

(2) a change in service due to amended regulatory requirements or rules;

(3) a change in types of services due to a change in applicable technology and medical practice utilized by the clinic;

(4) a change in the scope of a project approved by the commissioner; and

(5) a Minnesota-specific quality incentive program for CCBHCs that achieve target performance on select quality measures. The commissioner shall develop the quality incentive program, in consultation with stakeholders, with the following requirements:

(i) the same terms of performance must apply to all CCBHCs;

(ii) quality payments must be in addition to the prospective payment rate and must not exceed an amount equal to five percent of total medical assistance payments for CCBHC services provided during the applicable time period; and

(iii) the quality measures must be consistent with measures used by the commissioner for other health care programs.

(b) By February 15, 2020, the commissioner of human services shall consult with CCBHC providers to develop the rate methodology under paragraph (a). The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health services and medical assistance on the recommendations to the CCBHC rate methodology including any necessary statutory updates required for federal approval.

(c) The commissioner shall consult with CCBHCs and other providers receiving a prospective payment system rate to study a rate methodology that eliminates potential duplication of payment for CCBHC providers who also receive a separate prospective payment system rate. By February 15, 2021, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health services and medical assistance on findings and recommendations related to the rate methodology study under this paragraph, including any necessary statutory updates to implement recommendations.

Sec. 45. **DIRECTION TO COMMISSIONER; CONTINUUM OF CARE-BASED RATE METHODOLOGY.**

Subdivision 1. **Rate methodology.** (a) The commissioner of human services shall develop a comprehensive rate methodology for the consolidated chemical dependency treatment fund that reimburses substance use disorder treatment providers for the full continuum of care. The continuum of care-based rate methodology must replace the current rates with a uniform statewide methodology that accurately reflects provider expenses for providing required elements of substance use disorder outpatient and residential services.

(b) The continuum of care-based rate methodology must include:

(1) payment methodologies for substance use disorder treatment services provided under the consolidated chemical dependency treatment fund: (i) by a state-operated vendor and, if the criteria for patient placement is equivalent, by private vendors; or (ii) for persons who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community;

(2) compensation to providers who provide culturally competent consultation resources; and

(3) cost-based reimbursement for substance use disorder providers that use sustainable business models that individualize care and retain individuals in ongoing care at the lowest medically appropriate level.

(c) The commissioner of human services may contract with a health care policy consultant or other entity to:

(1) provide stakeholder facilitation and provider outreach services to develop the continuum of care-based rate methodology; and

(2) provide technical services to develop the continuum of care-based rate methodology.

(d) The commissioner of human services must develop comprehensive substance use disorder billing guidance for the continuum of care-based rate methodology.

(e) In developing the continuum of care-based rate methodology, the commissioner of human services must consult with the following stakeholders:

(1) representatives of at least one provider operating residential treatment services, one provider operating out-patient treatment services, one provider operating an opioid treatment program, and one provider operating both residential and out-patient treatment services;

(2) representatives of providers who operate in the seven-county metropolitan area and providers who operate in greater Minnesota; and

(3) representatives of both for-profit and nonprofit providers.

Subd. 2. **Reports.** (a) By November 1, 2020, the commissioner of human services shall report to the legislature on any modifications to the licensure standards necessary to align provider qualifications with the continuum of care-based rate methodology.

(b) The commissioner of human services shall propose legislation for the 2021 legislative session necessary to fully implement the continuum of care-based rate methodology.

Sec. 46. **REPEALER.**

Minnesota Statutes 2018, section 254B.03, subdivision 4a, is repealed.

## ARTICLE 7
## MENTAL HEALTH UNIFORM SERVICE STANDARDS

Section 1. Minnesota Statutes 2018, section 62A.152, subdivision 3, is amended to read:

Subd. 3. **Provider discrimination prohibited.** All group policies and group subscriber contracts that provide benefits for mental or nervous disorder treatments in a hospital must provide direct reimbursement for those services if performed by a mental health professional~~,~~ ~~as defined in sections 245.462, subdivision 18, clauses (1) to (5); and 245.4871, subdivision 27, clauses (1) to (5),~~ qualified according to section 245I.16, subdivision 2, to the extent that the services and treatment are within the scope of mental health professional licensure.

This subdivision is intended to provide payment of benefits for mental or nervous disorder treatments performed by a licensed mental health professional in a hospital and is not intended to change or add benefits for those services provided in policies or contracts to which this subdivision applies.

Sec. 2. Minnesota Statutes 2018, section 62A.3094, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in paragraphs (b) to (d) have the meanings given.

(b) "Autism spectrum disorders" means the conditions as determined by criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(c) "Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's condition, and diagnostic testing and preventative services. Medically necessary care must be consistent with generally accepted practice parameters as determined by physicians and licensed psychologists who typically manage patients who have autism spectrum disorders.

(d) "Mental health professional" means a mental health professional as ~~defined in section 245.4871, subdivision 27~~ described in section 245I.16, subdivision 2, clause (1), (2), (3), (4), or (6), who has training and expertise in autism spectrum disorder and child development.

Sec. 3. Minnesota Statutes 2018, section 148B.5301, subdivision 2, is amended to read:

Subd. 2. **Supervision.** (a) To qualify as a LPCC, an applicant must have completed 4,000 hours of post-master's degree supervised professional practice in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders in both children and adults. The supervised practice shall be conducted according to the requirements in paragraphs (b) to (e).

(b) The supervision must have been received under a contract that defines clinical practice and supervision from a mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6),~~ qualified according to section 245I.16, subdivision 2, or by a board-approved supervisor, who has at least two years of postlicensure experience in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders. All supervisors must meet the supervisor requirements in Minnesota Rules, part 2150.5010.

(c) The supervision must be obtained at the rate of two hours of supervision per 40 hours of professional practice. The supervision must be evenly distributed over the course of the supervised professional practice. At least 75 percent of the required supervision hours must be received in person. The remaining 25 percent of the required hours may be received by telephone or by audio or audiovisual electronic device. At least 50 percent of the required hours of supervision must be received on an individual basis. The remaining 50 percent may be received in a group setting.

(d) The supervised practice must include at least 1,800 hours of clinical client contact.

(e) The supervised practice must be clinical practice. Supervision includes the observation by the supervisor of the successful application of professional counseling knowledge, skills, and values in the differential diagnosis and treatment of psychosocial function, disability, or impairment, including addictions and emotional, mental, and behavioral disorders.

Sec. 4. Minnesota Statutes 2018, section 148E.0555, subdivision 6, is amended to read:

Subd. 6. **Qualifications during grandfathering for licensure as LICSW.** (a) To be licensed as a licensed independent clinical social worker, an applicant for licensure under this section must provide evidence satisfactory to the board that the individual has:

(1) completed a graduate degree in social work from a program accredited by the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar accrediting body designated by the board; or

(2) completed a graduate degree and is a mental health professional according to section ~~245.462, subdivision 18, clauses (1) to (6)~~ 245I.16, subdivision 2.

(b) To be licensed as a licensed independent clinical social worker, an applicant for licensure under this section must provide evidence satisfactory to the board that the individual has:

(1) practiced clinical social work as defined in section 148E.010, subdivision 6, including both diagnosis and treatment, and has met the supervised practice requirements specified in sections 148E.100 to 148E.125, excluding the 1,800 hours of direct clinical client contact specified in section 148E.115, subdivision 1, except that supervised practice hours obtained prior to August 1, 2011, must meet the requirements in Minnesota Statutes 2010, sections 148D.100 to 148D.125;

(2) submitted a completed, signed application and the license fee in section 148E.180;

(3) for applications submitted electronically, provided an attestation as specified by the board;

(4) submitted the criminal background check fee and a form provided by the board authorizing a criminal background check;

(5) paid the license fee in section 148E.180; and

(6) not engaged in conduct that was or would be in violation of the standards of practice specified in Minnesota Statutes 2010, sections 148D.195 to 148D.240, and sections 148E.195 to 148E.240. If the applicant has engaged in conduct that was or would be in violation of the standards of practice, the board may take action according to sections 148E.255 to 148E.270.

(c) An application which is not completed, signed, and accompanied by the correct license fee must be returned to the applicant, along with any fee submitted, and is void.

(d) By submitting an application for licensure, an applicant authorizes the board to investigate any information provided or requested in the application. The board may request that the applicant provide additional information, verification, or documentation.

(e) Within one year of the time the board receives an application for licensure, the applicant must meet all the requirements and provide all of the information requested by the board.

Sec. 5. Minnesota Statutes 2018, section 148E.120, subdivision 2, is amended to read:

Subd. 2. **Alternate supervisors.** (a) The board may approve an alternate supervisor as determined in this subdivision. The board shall approve up to 25 percent of the required supervision hours by a licensed mental health professional who is competent and qualified to provide supervision according to the mental health professional's respective licensing board, as established by section ~~245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6)~~ 245I.16, subdivision 2.

(b) The board shall approve up to 100 percent of the required supervision hours by an alternate supervisor if the board determines that:

(1) there are five or fewer supervisors in the county where the licensee practices social work who meet the applicable licensure requirements in subdivision 1;

(2) the supervisor is an unlicensed social worker who is employed in, and provides the supervision in, a setting exempt from licensure by section 148E.065, and who has qualifications equivalent to the applicable requirements specified in sections 148E.100 to 148E.115;

(3) the supervisor is a social worker engaged in authorized social work practice in Iowa, Manitoba, North Dakota, Ontario, South Dakota, or Wisconsin, and has the qualifications equivalent to the applicable requirements in sections 148E.100 to 148E.115; or

(4) the applicant or licensee is engaged in nonclinical authorized social work practice outside of Minnesota and the supervisor meets the qualifications equivalent to the applicable requirements in sections 148E.100 to 148E.115, or the supervisor is an equivalent mental health professional, as determined by the board, who is credentialed by a state, territorial, provincial, or foreign licensing agency; or

(5) the applicant or licensee is engaged in clinical authorized social work practice outside of Minnesota and the supervisor meets qualifications equivalent to the applicable requirements in section 148E.115, or the supervisor is an equivalent mental health

professional as determined by the board, who is credentialed by a state, territorial, provincial, or foreign licensing agency.

(c) In order for the board to consider an alternate supervisor under this section, the licensee must:

(1) request in the supervision plan and verification submitted according to section 148E.125 that an alternate supervisor conduct the supervision; and

(2) describe the proposed supervision and the name and qualifications of the proposed alternate supervisor. The board may audit the information provided to determine compliance with the requirements of this section.

Sec. 6. Minnesota Statutes 2018, section 148F.11, subdivision 1, is amended to read:

Subdivision 1. **Other professionals.** (a) Nothing in this chapter prevents members of other professions or occupations from performing functions for which they are qualified or licensed. This exception includes, but is not limited to: licensed physicians; registered nurses; licensed practical nurses; licensed psychologists and licensed psychological practitioners; members of the clergy provided such services are provided within the scope of regular ministries; American Indian medicine men and women; licensed attorneys; probation officers; licensed marriage and family therapists; licensed social workers; social workers employed by city, county, or state agencies; licensed professional counselors; licensed professional clinical counselors; licensed school counselors; registered occupational therapists or occupational therapy assistants; Upper Midwest Indian Council on Addictive Disorders (UMICAD) certified counselors when providing services to Native American people; city, county, or state employees when providing assessments or case management under Minnesota Rules, chapter 9530; and individuals defined in section 256B.0623, subdivision 5, clauses (1) ~~and (2)~~ to (4), providing integrated dual diagnosis treatment in adult mental health rehabilitative programs certified by the Department of Human Services under section 256B.0622 or 256B.0623.

(b) Nothing in this chapter prohibits technicians and resident managers in programs licensed by the Department of Human Services from discharging their duties as provided in Minnesota Rules, chapter 9530.

(c) Any person who is exempt from licensure under this section must not use a title incorporating the words "alcohol and drug counselor" or "licensed alcohol and drug counselor" or otherwise hold himself or herself out to the public by any title or description stating or implying that he or she is engaged in the practice of alcohol and drug counseling,

or that he or she is licensed to engage in the practice of alcohol and drug counseling, unless that person is also licensed as an alcohol and drug counselor. Persons engaged in the practice of alcohol and drug counseling are not exempt from the board's jurisdiction solely by the use of one of the titles in paragraph (a).

Sec. 7. Minnesota Statutes 2018, section 245.462, subdivision 6, is amended to read:

Subd. 6. **Community support services program.** "Community support services program" means services, other than inpatient or residential treatment services, provided or coordinated by an identified program and staff under the ~~clinical~~ treatment supervision of a mental health professional designed to help adults with serious and persistent mental illness to function and remain in the community. A community support services program includes:

(1) client outreach,

(2) medication monitoring,

(3) assistance in independent living skills,

(4) development of employability and work-related opportunities,

(5) crisis assistance,

(6) psychosocial rehabilitation,

(7) help in applying for government benefits, and

(8) housing support services.

The community support services program must be coordinated with the case management services specified in section 245.4711.

Sec. 8. Minnesota Statutes 2018, section 245.462, subdivision 8, is amended to read:

Subd. 8. **Day treatment services.** "Day treatment," "day treatment services," or "day treatment program" means ~~a structured program of treatment and care provided to an adult in or by: (1) a hospital accredited by the joint commission on accreditation of health organizations and licensed under sections 144.50 to 144.55; (2) a community mental health center under section 245.62; or (3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4712, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided at least two days a week by a multidisciplinary staff under the clinical supervision of a mental health professional. Day treatment may include education and consultation provided to families~~

~~and other individuals as part of the treatment process. The services are aimed at stabilizing the adult's mental health status, providing mental health services, and developing and improving the adult's independent living and socialization skills. The goal of day treatment is to reduce or relieve mental illness and to enable the adult to live in the community. Day treatment services are not a part of inpatient or residential treatment services. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. The commissioner may limit medical assistance reimbursement for day treatment to 15 hours per week per person~~ the treatment services described under section 256B.0625, subdivision 23.

Sec. 9. Minnesota Statutes 2018, section 245.462, subdivision 9, is amended to read:

Subd. 9. **Diagnostic assessment.** ~~(a)~~ "Diagnostic assessment" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a standard, extended, or brief diagnostic assessment, or an adult update~~ means the assessment described under section 256B.0671, subdivisions 2 to 4.

~~(b) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee, as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:~~

~~(1) age;~~

~~(2) description of symptoms, including reason for referral;~~

~~(3) history of mental health treatment;~~

~~(4) cultural influences and their impact on the client; and~~

~~(5) mental status examination.~~

~~(c) On the basis of the initial components, the professional or clinical trainee must draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem.~~

~~(d) Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.~~

~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible for psychological testing as part of the diagnostic process.~~

~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction with the diagnostic assessment process, a client is eligible for up to three individual or family psychotherapy sessions or family psychoeducation sessions or a combination of the above sessions not to exceed three sessions.~~

~~(g) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item B, subitem (3), unit (a), a brief diagnostic assessment may be used for a client's family who requires a language interpreter to participate in the assessment.~~

Sec. 10. Minnesota Statutes 2018, section 245.462, subdivision 14, is amended to read:

Subd. 14. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan of intervention, treatment, and services for an adult with mental illness that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individual responsible for providing treatment to the adult with mental illness~~ the individual treatment plan described under section 256B.0671, subdivisions 5 and 6.

Sec. 11. Minnesota Statutes 2018, section 245.462, subdivision 17, is amended to read:

Subd. 17. **Mental health practitioner.** ~~(a)~~ "Mental health practitioner" means a person ~~providing services to adults with mental illness or children with emotional disturbance who is qualified in at least one of the ways described in paragraphs (b) to (g). A mental health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults~~ qualified according to section 245I.16, subdivision 4.

~~(b) For purposes of this subdivision, a practitioner is qualified through relevant coursework if the practitioner completes at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and:~~

~~(1) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

~~(ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects;~~

~~(2) is fluent in the non-English language of the ethnic group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to adults with mental illness or children with emotional disturbance, and receives clinical supervision from a mental health professional at least once a week until the requirement of 2,000 hours of supervised experience is met;~~

~~(3) is working in a day treatment program under section 245.4712, subdivision 2; or~~

~~(4) has completed a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.~~

~~(c) For purposes of this subdivision, a practitioner is qualified through work experience if the person:~~

~~(1) has at least 4,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

~~(ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; or~~

~~(2) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, emotional disturbance, or substance use disorder, and receives clinical supervision as required by applicable statutes and rules from a mental health professional at least once a week until the requirement of 4,000 hours of supervised experience is met; or~~

~~(ii) traumatic brain injury or developmental disabilities; completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; and receives clinical supervision as required by applicable statutes and rules at least once a week from a mental health professional until the requirement of 4,000 hours of supervised experience is met.~~

~~(d) For purposes of this subdivision, a practitioner is qualified through a graduate student internship if the practitioner is a graduate student in behavioral sciences or related fields and is formally assigned by an accredited college or university to an agency or facility for clinical training.~~

~~(e) For purposes of this subdivision, a practitioner is qualified by a bachelor's or master's degree if the practitioner:~~

~~(1) holds a master's or other graduate degree in behavioral sciences or related fields; or~~

~~(2) holds a bachelor's degree in behavioral sciences or related fields and completes a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.~~

~~(f) For purposes of this subdivision, a practitioner is qualified as a vendor of medical care if the practitioner meets the definition of vendor of medical care in section 256B.02, subdivision 7, paragraphs (b) and (c), and is serving a federally recognized tribe.~~

~~(g) For purposes of medical assistance coverage of diagnostic assessments, explanations of findings, and psychotherapy under section 256B.0625, subdivision 65, a mental health practitioner working as a clinical trainee means that the practitioner's clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of direct practice, treatment team collaboration, continued professional learning, and job management. The practitioner must also:~~

~~(1) comply with requirements for licensure or board certification as a mental health professional, according to the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A, including supervised practice in the delivery of mental health services for the treatment of mental illness; or~~

~~(2) be a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional according to the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A.~~

~~(h) For purposes of this subdivision, "behavioral sciences or related fields" has the meaning given in section 256B.0623, subdivision 5, paragraph (d).~~

~~(i) Notwithstanding the licensing requirements established by a health-related licensing board, as defined in section 214.01, subdivision 2, this subdivision supersedes any other statute or rule.~~

Sec. 12. Minnesota Statutes 2018, section 245.462, subdivision 18, is amended to read:

Subd. 18. **Mental health professional.** "Mental health professional" means a person ~~providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:~~ qualified according to section 245I.16, subdivision 2.

~~(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to 148.285; and:~~

~~(i) who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization; or~~

~~(ii) who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(2) in clinical social work: a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(3) in psychology: an individual licensed by the Board of Psychology under sections 148.88 to 148.98 who has stated to the Board of Psychology competencies in the diagnosis and treatment of mental illness;~~

~~(4) in psychiatry: a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry, or an osteopathic physician licensed under chapter 147 and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification in psychiatry;~~

~~(5) in marriage and family therapy: the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(6) in licensed professional clinical counseling, the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness; or~~

~~(7) in allied fields: a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness.~~

Sec. 13. Minnesota Statutes 2018, section 245.462, subdivision 21, is amended to read:

Subd. 21. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the ~~clinical~~ treatment supervision of a mental health professional to adults with mental illness who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Sec. 14. Minnesota Statutes 2018, section 245.462, subdivision 23, is amended to read:

Subd. 23. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program under the ~~clinical~~ treatment supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit, that must be licensed as a residential treatment program for adults with mental illness under Minnesota Rules, parts 9520.0500 to 9520.0670, or other rules adopted by the commissioner.

Sec. 15. Minnesota Statutes 2018, section 245.462, is amended by adding a subdivision to read:

Subd. 27. **Treatment supervision.** "Treatment supervision" means the treatment supervision described under section 245I.18.

Sec. 16. Minnesota Statutes 2018, section 245.467, subdivision 2, is amended to read:

Subd. 2. **Diagnostic assessment.** ~~All providers of residential, acute care hospital inpatient, and regional treatment centers must complete a diagnostic assessment for each of their clients within five days of admission. Providers of day treatment services must complete a diagnostic assessment within five days after the adult's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available and has been completed within three years preceding admission, only an adult diagnostic assessment update is necessary. An "adult diagnostic assessment update" means a written summary by a mental health professional of the adult's current mental health status and service needs and includes a face-to-face interview with the adult. If the adult's mental health status has~~

~~changed markedly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required. Compliance with the provisions of this subdivision does not ensure eligibility for medical assistance reimbursement under chapter 256B.~~ Providers of services governed by this section shall complete a diagnostic assessment according to the standards of section 256B.0671, including for services to a person not eligible for medical assistance.

Sec. 17. Minnesota Statutes 2018, section 245.467, subdivision 3, is amended to read:

Subd. 3. **Individual treatment plans.** ~~All providers of outpatient services, day treatment services, residential treatment, acute care hospital inpatient treatment, and all regional treatment centers must develop an individual treatment plan for each of their adult clients. The individual treatment plan must be based on a diagnostic assessment. To the extent possible, the adult client shall be involved in all phases of developing and implementing the individual treatment plan. Providers of residential treatment and acute care hospital inpatient treatment, and all regional treatment centers must develop the individual treatment plan within ten days of client intake and must review the individual treatment plan every 90 days after intake. Providers of day treatment services must develop the individual treatment plan before the completion of five working days in which service is provided or within 30 days after the diagnostic assessment is completed or obtained, whichever occurs first. Providers of outpatient services must develop the individual treatment plan within 30 days after the diagnostic assessment is completed or obtained or by the end of the second session of an outpatient service, not including the session in which the diagnostic assessment was provided, whichever occurs first. Outpatient and day treatment services providers must review the individual treatment plan every 90 days after intake.~~ Providers of services governed by this section shall complete an individual treatment plan according to the standards of section 256B.0671, subdivisions 5 and 6, including for services to a person not eligible for medical assistance.

Sec. 18. Minnesota Statutes 2018, section 245.469, subdivision 1, is amended to read:

Subdivision 1. **Availability of emergency services.** ~~By July 1, 1988,~~ County boards must provide or contract for enough emergency services within the county to meet the needs of adults in the county who are experiencing an emotional crisis or mental illness. Clients may be required to pay a fee according to section 245.481. Emergency service providers shall not delay the timely provision of emergency service because of delays in determining this fee or because of the unwillingness or inability of the client to pay the fee. Emergency services must include assessment, crisis intervention, and appropriate case disposition. A

tribal authority that accepts crisis grant funding has the same responsibilities as county boards within the tribal authority's designated service area. Emergency services must:

(1) promote the safety and emotional stability of adults with mental illness or emotional crises;

(2) minimize further deterioration of adults with mental illness or emotional crises;

(3) help adults with mental illness or emotional crises to obtain ongoing care and treatment; ~~and~~

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs~~.~~; and

(5) provide support, psychoeducation, and referrals to family members, friends, service providers, or other third parties on behalf of a recipient in need of emergency services.

Sec. 19. Minnesota Statutes 2018, section 245.469, subdivision 2, is amended to read:

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to adults with mental illness provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, a clinical trainee, or a mental health practitioner~~, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional~~.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional, clinical trainee, or mental health practitioner ~~after January 1, 1991,~~ if the county documents that:

(1) mental health professionals, clinical trainees, or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives ~~clinical~~ treatment supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received and their responses;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) Whenever emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

Sec. 20. Minnesota Statutes 2018, section 245.470, subdivision 1, is amended to read:

Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or contract for enough outpatient services within the county to meet the needs of adults with mental illness residing in the county. Services may be provided directly by the county through county-operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; by contract with privately operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; by contract with hospital mental health outpatient programs certified by the Joint Commission on Accreditation of Hospital Organizations; or by contract with a licensed mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6)~~. Clients may be required to pay a fee according to section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;

(2) conducting psychological testing;

(3) developing or modifying individual treatment plans;

(4) making referrals and recommending placements as appropriate;

(5) treating an adult's mental health needs through therapy;

(6) prescribing and managing medication and evaluating the effectiveness of prescribed medication; and

(7) preventing placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs.

(b) County boards may request a waiver allowing outpatient services to be provided in a nearby trade area if it is determined that the client can best be served outside the county.

Sec. 21. Minnesota Statutes 2018, section 245.4712, subdivision 2, is amended to read:

Subd. 2. **Day treatment services provided.** (a) Day treatment services must be developed as a part of the community support services available to adults with serious and persistent mental illness residing in the county. Adults may be required to pay a fee according to section 245.481. Day treatment services must be designed to:

(1) provide a structured environment for treatment;

(2) provide support for residing in the community;

(3) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client need;

(4) coordinate with or be offered in conjunction with a local education agency's special education program; and

(5) operate on a continuous basis throughout the year.

(b) For purposes of complying with medical assistance requirements, an adult day treatment program must comply with the method of ~~clinical~~ treatment supervision specified in ~~Minnesota Rules, part 9505.0371, subpart 4~~ section 245I.18. ~~The clinical supervision must be performed by a qualified supervisor who satisfies the requirements of Minnesota Rules, part 9505.0371, subpart 5.~~

A day treatment program must demonstrate compliance with this ~~clinical~~ treatment supervision requirement by the commissioner's review and approval of the program according to ~~Minnesota Rules, part 9505.0372, subpart 8~~ section 256B.0625, subdivision 23.

(c) County boards may request a waiver from including day treatment services if they can document that:

(1) an alternative plan of care exists through the county's community support services for clients who would otherwise need day treatment services;

(2) day treatment, if included, would be duplicative of other components of the community support services; and

(3) county demographics and geography make the provision of day treatment services cost ineffective and infeasible.

Sec. 22. Minnesota Statutes 2018, section 245.472, subdivision 2, is amended to read:

Subd. 2. **Specific requirements.** Providers of residential services must be licensed under applicable rules adopted by the commissioner and must ~~be clinically supervised~~ provide treatment supervision by a mental health professional. ~~Persons employed in facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0670, in the capacity of program director as of July 1, 1987, in accordance with Minnesota Rules, parts 9520.0500 to 9520.0670, may be allowed to continue providing clinical supervision within a facility, provided they continue to be employed as a program director in a facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670.~~

Sec. 23. Minnesota Statutes 2018, section 245.4863, is amended to read:

**245.4863 INTEGRATED CO-OCCURRING DISORDER TREATMENT.**

(a) The commissioner shall require individuals who perform chemical dependency assessments to screen clients for co-occurring mental health disorders, and staff who perform mental health diagnostic assessments to screen for co-occurring substance use disorders. Screening tools must be approved by the commissioner. If a client screens positive for a co-occurring mental health or substance use disorder, the individual performing the screening must document what actions will be taken in response to the results and whether further assessments must be performed.

(b) Notwithstanding paragraph (a), screening is not required when:

(1) the presence of co-occurring disorders was documented for the client in the past 12 months;

(2) the client is currently receiving co-occurring disorders treatment;

(3) the client is being referred for co-occurring disorders treatment; or

(4) a mental health professional, as ~~defined in Minnesota Rules, part 9505.0370, subpart 18~~ provided by section 245I.16, subdivision 2, who is competent to perform diagnostic

assessments of co-occurring disorders is performing a diagnostic assessment that meets the requirements in Minnesota Rules, part 9533.0090, subpart 5, to identify whether the client may have co-occurring mental health and chemical dependency disorders. If an individual is identified to have co-occurring mental health and substance use disorders, the assessing mental health professional must document what actions will be taken to address the client's co-occurring disorders.

(c) The commissioner shall adopt rules as necessary to implement this section. The commissioner shall ensure that the rules are effective on July 1, 2013, thereby establishing a certification process for integrated dual disorder treatment providers and a system through which individuals receive integrated dual diagnosis treatment if assessed as having both a substance use disorder and either a serious mental illness or emotional disturbance.

(d) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation for the provision of integrated dual diagnosis treatment to persons with co-occurring disorders.

Sec. 24. Minnesota Statutes 2018, section 245.4871, subdivision 9a, is amended to read:

Subd. 9a. **Crisis ~~assistance~~ planning.** "Crisis ~~assistance~~ planning" means ~~assistance to the child, the child's family, and all providers of services to the child to: recognize factors precipitating a mental health crisis, identify behaviors related to the crisis, and be informed of available resources to resolve the crisis. Crisis assistance requires the development of a plan which addresses prevention and intervention strategies to be used in a potential crisis. Other interventions include: (1) arranging for admission to acute care hospital inpatient treatment; (2) crisis placement; (3) community resources for follow-up; and (4) emotional support to the family during crisis. Crisis assistance does not include services designed to secure the safety of a child who is at risk of abuse or neglect or necessary emergency services.~~ the development of a written plan to assist a child's family in preventing and addressing a potential crisis and is distinct from the immediate provision of mental health mobile crisis intervention services as defined in section 256B.0944. The plan must address prevention, de-escalation, and intervention strategies to be used in a crisis. The plan identifies factors that might precipitate a crisis, behaviors or symptoms related to the emergence of a crisis, and the resources available to resolve a crisis. The plan must include planning for the following potential needs: (1) acute care; (2) crisis placement; (3) community resources for follow-up; and (4) emotional support to the family during crisis. Crisis planning excludes services designed to secure the safety of a child who is at risk of abuse or neglect or necessary emergency services.

Sec. 25. Minnesota Statutes 2018, section 245.4871, subdivision 10, is amended to read:

Subd. 10. **Day treatment services.** "Day treatment," "day treatment services," or "day treatment program" means a structured program of treatment and care provided to a child in:

(1) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55;

(2) a community mental health center under section 245.62;

(3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475; ~~or~~

(4) an entity that operates a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475, that is under contract with an entity that is under contract with a county board~~.~~; or

(5) an entity that operates a program certified under section 256B.0943.

Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided for a minimum two-hour time block by a multidisciplinary staff under the clinical supervision of a mental health professional. Day treatment may include education and consultation provided to families and other individuals as an extension of the treatment process. The services are aimed at stabilizing the child's mental health status, and developing and improving the child's daily independent living and socialization skills. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. Day treatment services are not a part of inpatient hospital or residential treatment services.

A day treatment service must be available to a child up to 15 hours a week throughout the year and must be coordinated with, integrated with, or part of an education program offered by the child's school.

Sec. 26. Minnesota Statutes 2018, section 245.4871, subdivision 11a, is amended to read:

Subd. 11a. **Diagnostic assessment.** ~~(a)~~ "Diagnostic assessment" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a standard, extended, or brief diagnostic assessment, or an adult update.~~ means the assessment described under section 256B.0671, subdivisions 2 to 4.

~~(b) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee, as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:~~

~~(1) age;~~

~~(2) description of symptoms, including reason for referral;~~

~~(3) history of mental health treatment;~~

~~(4) cultural influences and their impact on the client; and~~

~~(5) mental status examination.~~

~~(c) On the basis of the brief components, the professional or clinical trainee must draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem.~~

~~(d) Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.~~

~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible for psychological testing as part of the diagnostic process.~~

~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction with the diagnostic assessment process, a client is eligible for up to three individual or family psychotherapy sessions or family psychoeducation sessions or a combination of the above sessions not to exceed three sessions.~~

Sec. 27. Minnesota Statutes 2018, section 245.4871, subdivision 17, is amended to read:

Subd. 17. **Family community support services.** "Family community support services" means services provided under the ~~clinical~~ treatment supervision of a mental health professional and designed to help each child with severe emotional disturbance to function and remain with the child's family in the community. Family community support services do not include acute care hospital inpatient treatment, residential treatment services, or regional treatment center services. Family community support services include:

(1) client outreach to each child with severe emotional disturbance and the child's family;

(2) medication monitoring where necessary;

(3) assistance in developing independent living skills;

(4) assistance in developing parenting skills necessary to address the needs of the child with severe emotional disturbance;

(5) assistance with leisure and recreational activities;

(6) crisis assistance, including crisis placement and respite care;

(7) professional home-based family treatment;

(8) foster care with therapeutic supports;

(9) day treatment;

(10) assistance in locating respite care and special needs day care; and

(11) assistance in obtaining potential financial resources, including those benefits listed in section 245.4884, subdivision 5.

Sec. 28. Minnesota Statutes 2018, section 245.4871, subdivision 21, is amended to read:

Subd. 21. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan of intervention, treatment, and services for a child with an emotional disturbance that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. An individual treatment plan for a child must be developed in conjunction with the family unless clinically inappropriate. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment to the child with an emotional disturbance~~ the individual treatment plan described under section 256B.0671, subdivisions 5 and 6.

Sec. 29. Minnesota Statutes 2018, section 245.4871, subdivision 26, is amended to read:

Subd. 26. **Mental health practitioner.** "Mental health practitioner" ~~has the meaning given in~~ means a person qualified according to section ~~245.462, subdivision 17~~ 245I.16, subdivision 4.

Sec. 30. Minnesota Statutes 2018, section 245.4871, subdivision 27, is amended to read:

Subd. 27. **Mental health professional.** "Mental health professional" means a person ~~providing clinical services in the diagnosis and treatment of children's emotional disorders. A mental health professional must have training and experience in working with children~~

~~consistent with the age group to which the mental health professional is assigned. A mental health professional must be qualified in at least one of the following ways:~~ qualified according to section 245I.16, subdivision 2.

~~(1) in psychiatric nursing, the mental health professional must be a registered nurse who is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(2) in clinical social work, the mental health professional must be a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders;~~

~~(3) in psychology, the mental health professional must be an individual licensed by the board of psychology under sections 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental disorders;~~

~~(4) in psychiatry, the mental health professional must be a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry or an osteopathic physician licensed under chapter 147 and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification in psychiatry;~~

~~(5) in marriage and family therapy, the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances;~~

~~(6) in licensed professional clinical counseling, the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances; or~~

~~(7) in allied fields, the mental health professional must be a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields,~~

~~with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of emotional disturbances.~~

Sec. 31. Minnesota Statutes 2018, section 245.4871, subdivision 29, is amended to read:

Subd. 29. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the ~~clinical~~ treatment supervision of a mental health professional to children with emotional disturbances who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Sec. 32. Minnesota Statutes 2018, section 245.4871, subdivision 32, is amended to read:

Subd. 32. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program under the ~~clinical~~ treatment supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit, that must be licensed as a residential treatment program for children with emotional disturbances under Minnesota Rules, parts 2960.0580 to 2960.0700, or other rules adopted by the commissioner.

Sec. 33. Minnesota Statutes 2018, section 245.4871, subdivision 34, is amended to read:

Subd. 34. **Therapeutic support of foster care.** "Therapeutic support of foster care" means the mental health training and mental health support services and ~~clinical~~ treatment supervision provided by a mental health professional to foster families caring for children with severe emotional disturbance to provide a therapeutic family environment and support for the child's improved functioning. Therapeutic support of foster care includes services provided under section 256B.0946.

Sec. 34. Minnesota Statutes 2018, section 245.4876, subdivision 2, is amended to read:

Subd. 2. **Diagnostic assessment.** ~~All residential treatment facilities and acute care hospital inpatient treatment facilities that provide mental health services for children must complete a diagnostic assessment for each of their child clients within five working days of admission. Providers of day treatment services for children must complete a diagnostic assessment within five days after the child's second visit or 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available and has been completed within 180 days preceding admission, only updating is necessary. "Updating" means a~~

~~written summary by a mental health professional of the child's current mental health status and service needs. If the child's mental health status has changed markedly since the child's most recent diagnostic assessment, a new diagnostic assessment is required. Compliance with the provisions of this subdivision does not ensure eligibility for medical assistance reimbursement under chapter 256B.~~ Providers of services governed by this section shall complete a diagnostic assessment according to the standards of section 256B.0671, including for services to a person not eligible for medical assistance.

Sec. 35. Minnesota Statutes 2018, section 245.4876, subdivision 3, is amended to read:

Subd. 3. **Individual treatment plans.** ~~All providers of outpatient services, day treatment services, professional home-based family treatment, residential treatment, and acute care hospital inpatient treatment, and all regional treatment centers that provide mental health services for children must develop an individual treatment plan for each child client. The individual treatment plan must be based on a diagnostic assessment. To the extent appropriate, the child and the child's family shall be involved in all phases of developing and implementing the individual treatment plan. Providers of residential treatment, professional home-based family treatment, and acute care hospital inpatient treatment, and regional treatment centers must develop the individual treatment plan within ten working days of client intake or admission and must review the individual treatment plan every 90 days after intake, except that the administrative review of the treatment plan of a child placed in a residential facility shall be as specified in sections 260C.203 and 260C.212, subdivision 9. Providers of day treatment services must develop the individual treatment plan before the completion of five working days in which service is provided or within 30 days after the diagnostic assessment is completed or obtained, whichever occurs first. Providers of outpatient services must develop the individual treatment plan within 30 days after the diagnostic assessment is completed or obtained or by the end of the second session of an outpatient service, not including the session in which the diagnostic assessment was provided, whichever occurs first. Providers of outpatient and day treatment services must review the individual treatment plan every 90 days after intake.~~ Providers of services governed by this section shall complete an individual treatment plan according to the standards of section 256B.0671, subdivisions 5 and 6, including for services to a person not eligible for medical assistance.

Sec. 36. Minnesota Statutes 2018, section 245.4879, subdivision 1, is amended to read:

Subdivision 1. **Availability of emergency services.** County boards must provide or contract for enough mental health emergency services within the county to meet the needs

of children, and children's families when clinically appropriate, in the county who are experiencing an emotional crisis or emotional disturbance. The county board shall ensure that parents, providers, and county residents are informed about when and how to access emergency mental health services for children. A child or the child's parent may be required to pay a fee according to section 245.481. Emergency service providers shall not delay the timely provision of emergency service because of delays in determining this fee or because of the unwillingness or inability of the parent to pay the fee. Emergency services must include assessment, crisis intervention, and appropriate case disposition. A tribal authority that accepts crisis grant funding has the same responsibilities as county boards within the tribal authority's designated service area. Emergency services must:

(1) promote the safety and emotional stability of children with emotional disturbances or emotional crises;

(2) minimize further deterioration of the child with emotional disturbance or emotional crisis;

(3) help each child with an emotional disturbance or emotional crisis to obtain ongoing care and treatment; ~~and~~

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet the child's needs~~.~~; and

(5) provide support, psychoeducation, and referrals to family members, service providers, or other third parties on behalf of a client in need of emergency services.

Sec. 37. Minnesota Statutes 2018, section 245.4879, subdivision 2, is amended to read:

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to the child with an emotional disturbance provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, a clinical trainee, or a mental health practitioner~~, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional~~.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional, clinical trainee, or mental health practitioner ~~after January 1, 1991,~~ if the county documents that:

(1) mental health professionals, clinical trainees, or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives ~~clinical~~ treatment supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) When emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

Sec. 38. Minnesota Statutes 2018, section 245.488, subdivision 1, is amended to read:

Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or contract for enough outpatient services within the county to meet the needs of each child with emotional disturbance residing in the county and the child's family. Services may be provided directly by the county through county-operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; by contract with privately operated mental health centers or mental health clinics approved by the

commissioner under section 245.69, subdivision 2; by contract with hospital mental health outpatient programs certified by the Joint Commission on Accreditation of Hospital Organizations; or by contract with a licensed mental health professional ~~as defined in section 245.4871, subdivision 27, clauses (1) to (6)~~. A child or a child's parent may be required to pay a fee based in accordance with section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;

(2) conducting psychological testing;

(3) developing or modifying individual treatment plans;

(4) making referrals and recommending placements as appropriate;

(5) treating the child's mental health needs through therapy; and

(6) prescribing and managing medication and evaluating the effectiveness of prescribed medication.

(b) County boards may request a waiver allowing outpatient services to be provided in a nearby trade area if it is determined that the child requires necessary and appropriate services that are only available outside the county.

(c) Outpatient services offered by the county board to prevent placement must be at the level of treatment appropriate to the child's diagnostic assessment.

Sec. 39. Minnesota Statutes 2018, section 245.696, is amended by adding a subdivision to read:

Subd. 3. **Certification of mental health peer specialists and mental health family peer specialists.** The commissioner shall develop a process to certify mental health peer specialists and mental health family peer specialists according to federal guidelines and section 245I.16, subdivisions 10 to 13, for a provider entity to bill for reimbursable services. The training and certification curriculum must teach individuals specific skills relevant to providing peer support as appropriate for individual or family peers.

Sec. 40. **[245I.01] PURPOSE AND CITATION.**

Subdivision 1. **Citation.** This chapter may be cited as the "Mental Health Uniform Service Standards Act."

Subd. 2. **Purpose.** In accordance with sections 245.461 and 245.487, to create a system of mental health care that is unified, accountable, and comprehensive, and to promote the recovery of Minnesotans from mental illnesses, the state's public policy is to support quality

outpatient and residential mental health services reimbursable by public and private health insurance programs. Further, the state's public policy is to ensure the safety, rights, and well-being of individuals served in these programs.

Subd. 3. **Variances.** If the conditions in section 245A.04, subdivision 9, are met, the commissioner may grant variances to the requirements in this chapter that do not affect a client's health or safety.

Sec. 41. **[245I.02] DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of this chapter the terms in this section have the meanings given them.

Subd. 2. **Approval.** "Approval" means the documented review of, opportunity to request changes to, and agreement with a treatment document by a treatment supervisor or by a client. Approval may be demonstrated by written signature, secure electronic signature, or documented oral approval.

Subd. 3. **Behavioral sciences or related fields.** "Behavioral sciences or related fields" means an education from an accredited college or university in a field including but not limited to social work, psychology, sociology, community counseling, family social science, child development, child psychology, community mental health, addiction counseling, counseling and guidance, special education, and other similar fields as approved by the commissioner.

Subd. 4. **Certified rehabilitation specialist.** "Certified rehabilitation specialist" means a staff person qualified according to section 245I.16, subdivision 8.

Subd. 5. **Child.** "Child" means a client under 18 years of age, or a client under 21 years of age who is eligible for a service otherwise provided to persons under 18 years of age.

Subd. 6. **Client.** "Client" means a person who is seeking or receiving services regulated under this chapter. For the purpose of consent to services, this term includes a parent, guardian, or other individual authorized to consent to services by law.

Subd. 7. **Clinical trainee.** "Clinical trainee" means a staff person qualified according to section 245I.16, subdivision 6.

Subd. 8. **Clinician.** "Clinician" means a mental health professional or clinical trainee who is performing diagnostic assessment, testing, or psychotherapy.

Subd. 9. **Commissioner.** "Commissioner" means the commissioner of human services or the commissioner's designee.

Subd. 10. **Diagnostic assessment.** "Diagnostic assessment" means the evaluation and report of a client's potential diagnoses conducted by a clinician. For a client receiving publicly funded services, a diagnostic assessment must meet the standards of section 256B.0671, subdivisions 2 to 4.

Subd. 11. **Diagnostic formulation.** "Diagnostic formulation" means a written analysis and explanation of the information obtained from a clinical assessment to develop a hypothesis about the cause and nature of the presenting problems and identify a framework for developing the most suitable treatment approach.

Subd. 12. **Individual treatment plan.** "Individual treatment plan" means the formulation of planned services that are responsive to the needs and goals of a client. For a client receiving publicly funded services, an individual treatment plan must meet the standards of section 256B.0671, subdivisions 5 and 6.

Subd. 13. **Mental health behavioral aide.** "Mental health behavioral aide" means a staff person qualified according to section 245I.16, subdivision 16.

Subd. 14. **Mental health certified family peer specialist.** "Mental health certified family peer specialist" means a staff person qualified according to section 245I.16, subdivision 12.

Subd. 15. **Mental health certified peer specialist.** "Mental health certified peer specialist" means a staff person qualified according to section 245I.16, subdivision 10.

Subd. 16. **Mental health practitioner.** "Mental health practitioner" means a staff person qualified according to section 245I.16, subdivision 4.

Subd. 17. **Mental health professional.** "Mental health professional" means a staff person qualified according to section 245I.16, subdivision 2.

Subd. 18. **Mental health rehabilitation worker.** "Mental health rehabilitation worker" means a staff person qualified according to section 245I.16, subdivision 14.

Subd. 19. **Personnel file.** "Personnel file" means the set of records under section 245I.13, paragraph (a). Personnel files excludes information related to a person's employment not enumerated in section 245I.13.

Subd. 20. **Provider entity.** "Provider entity" means the organization, governmental unit, corporation, or other legal body that is enrolled, certified, licensed, or otherwise authorized by the commissioner to provide the services described in this chapter.

Subd. 21. **Responsivity factors.** "Responsivity factors" means the factors other than the diagnostic formulation that may modify an individual's treatment needs. This includes learning style, ability, cognitive function, cultural background, and personal circumstance. Documentation of responsivity factors includes an analysis of how an individual's strengths may be reflected in the planned delivery of services.

Subd. 22. **Risk factors.** "Risk factors" means factors that predispose a client to engage in potentially harmful behaviors to themselves or others.

Subd. 23. **Strengths.** "Strengths" means inner characteristics, virtues, external relationships, activities, and connections to resources that contribute to resilience and core competencies and can be built on to support recovery.

Subd. 24. **Trauma.** "Trauma" means an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Trauma includes the cumulative emotional or psychological harm of group traumatic experiences, transmitted across generations within a community, often associated with racial and ethnic population groups in the country who have suffered major intergenerational losses.

Subd. 25. **Treatment supervision.** "Treatment supervision" means the direction and evaluation of individual assessment, treatment planning, and service delivery for each client when services are delivered by an individual who is not a licensed mental health professional or certified rehabilitation specialist as provided by section 245I.18.

Sec. 42. **[245I.10] TRAINING REQUIRED.**

Subdivision 1. **Training plan.** A provider entity must develop a plan to ensure that staff persons receive orientation and ongoing training. The plan must include:

(1) a formal process to evaluate the training needs of each staff person. An annual performance evaluation satisfies this requirement;

(2) a description of how the provider entity conducts annual training, including whether annual training is based on a staff person's hire date or a specified annual cycle determined by the program; and

(3) a description of how the provider entity determines when a staff person needs additional training, including the timelines in which the additional training is provided.

Subd. 2. **Documentation of orientation and training.** (a) The provider entity must provide training in accordance with the training plan and must document that orientation and training was provided. All training programs and materials used by the provider entity must be available for review by regulatory agencies. The documentation must include the following:

(1) topic covered in the training;

(2) identification of the trainee;

(3) name and credentials of the trainer;

(4) method of evaluating competency upon completion of training;

(5) date of training; and

(6) length of training, in hours.

(b) Documentation of a continuing education credit accepted by the governing health-related licensing board is sufficient for purposes of this subdivision.

Subd. 3. **Orientation.** (a) Before providing direct contact services, a staff person must receive orientation on:

(1) patient rights as identified in section 144.651;

(2) vulnerable adult and minor maltreatment requirements in sections 245A.65, subdivision 3; 626.556, subdivisions 2, 3, and 7; 626.557; and 626.5572;

(3) the Minnesota Health Records Act, including confidentiality, family engagement according to section 144.294, and client privacy;

(4) program policies and procedures;

(5) emergency procedures appropriate to the position, including but not limited to fires, inclement weather, missing persons, and medical emergencies;

(6) professional boundaries;

(7) behavior management, crisis intervention, and stabilization techniques;

(8) specific needs of individuals served by the program, including but not limited to developmental status, cognitive functioning, and physical and mental abilities; and

(9) training related to the specific activities and job functions for which the staff person is responsible to carry out, including documentation of the delivery of services.

(b) A staff person must receive orientation on the following topics within 90 calendar days of a staff person first providing direct contact services:

(1) trauma-informed care;

(2) family- and person-centered individual treatment plans, seeking partnership with parents and identified supports, and shared decision making and engagement;

(3) treatment for co-occurring substance use problems, including the definitions of co-occurring disorders, prevalence of co-occurring disorders, common signs and symptoms of co-occurring disorders, and the etiology of co-occurring disorders;

(4) psychotropic medications, side effects, and safe medication management;

(5) family systems and promoting culturally appropriate support networks;

(6) culturally responsive treatment practices;

(7) recovery concepts and principles;

(8) building resiliency through a strength-based approach;

(9) person-centered planning and positive support strategies; and

(10) other training relevant to the staff person's role and responsibilities.

(c) A provider entity may deem a staff person to have met an orientation requirement in paragraph (b) if the staff person has received equivalent postsecondary education in the previous four years or training experience in the previous two years. The training plan must describe the process and location for verification and documentation of previous training experience.

(d) A provider entity may deem a mental health professional to have met a requirement of paragraph (a), clauses (6) to (9), and paragraph (b) after an evaluation of the mental health professional's competency, including by interview.

Subd. 4. **Annual training.** (a) A provider entity shall ensure that staff persons who are not licensed mental health professionals receive 15 hours of training each year after the first year of employment.

(b) A licensed mental health professional must follow specific training requirements as determined by the professional's governing health-related licensing board.

(c) All staff persons, including licensed mental health professionals, must receive annual training on the topics in subdivision 3, paragraph (a), clauses (2) and (5).

(d) The selection of additional training topics must be based on program needs and staff persons' competency.

Subd. 5. **Training for services provided to children.** (a) Training and orientation required under this section for a staff person working with children must be aligned to the developmental characteristics of the children served in the program and address the needs of children in the context of the family, support system, and culture. This includes orientation under subdivision 3 on the following topics: (1) child development; (2) working with children and children's support systems; (3) adverse childhood experiences, cognitive functioning, and physical and mental abilities; and (4) understanding family perspective.

(b) For a mental health behavioral aide, orientation in the first 90 days of service must include a parent team training utilizing a curriculum approved by the commissioner.

Sec. 43. **[245I.13] PERSONNEL FILES.**

(a) For each staff person, a provider entity shall maintain a personnel file that includes:

(1) verification of the staff person's qualifications including training, education, and licensure;

(2) documentation related to the staff person's background study;

(3) the date of hire;

(4) the effective date of specific duties and responsibilities including the date that the staff person begins direct contact with a client;

(5) documentation of orientation;

(6) records of training, license renewal, and educational activities completed during the staff person's employment;

(7) annual job performance evaluations; and

(8) records of clinical supervision, if applicable.

(b) Personnel files must be made accessible to the commissioner upon request. Personnel files must be readily accessible for review but need not be kept in a single location.

Sec. 44. **[245I.16] PROVIDER QUALIFICATIONS AND SCOPE OF PRACTICE.**

Subdivision 1. **Tribal providers.** For purposes of this section, a tribal entity may credential an individual under section 256B.02, subdivision 7, paragraphs (b) and (c).

Subd. 2. **Mental health professional qualifications.** The following individuals may provide services as a mental health professional:

(1) a registered nurse who is licensed under sections 148.171 to 148.285 and is certified as a (i) clinical nurse specialist in child or adolescent, family, or adult psychiatric and mental health nursing by a national certification organization, or (ii) nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization;

(2) a licensed independent clinical social worker as defined in section 148E.050, subdivision 5;

(3) a psychologist licensed by the Board of Psychology under sections 148.88 to 148.98;

(4) a physician licensed under chapter 147 if the physician is: (i) certified by the American Board of Psychiatry and Neurology; (ii) certified by the American Osteopathic Board of Neurology and Psychiatry; or (iii) eligible for board certification in psychiatry;

(5) a marriage and family therapist licensed under sections 148B.29 to 148B.39; or

(6) a licensed professional clinical counselor licensed under section 148B.5301.

Subd. 3. **Mental health professional scope of practice.** A mental health professional shall maintain a valid license with the mental health professional's governing health-related licensing board and shall only provide services within the scope of practice as determined by the health-related licensing board.

Subd. 4. **Mental health practitioner qualifications.** (a) An individual who is qualified in at least one of the ways described in paragraphs (b) to (d) may serve as a mental health practitioner.

(b) An individual is qualified through relevant coursework if the individual completes at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and:

(1) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with: (i) mental illness, substance use disorder, or emotional disturbance; or (ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance use disorder, and psychotropic medications and side effects;

(2) is fluent in the non-English language of the ethnic group to which at least 50 percent of the individual's clients belong, completes 40 hours of training in the delivery of services to adults with mental illness or children with emotional disturbance, and receives treatment

supervision from a mental health professional at least once per week until the requirement of 2,000 hours of supervised experience is met;

(3) is working in a day treatment program under section 245.4712, subdivision 2; or

(4) has completed a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.

(c) An individual is qualified through work experience if the individual:

(1) has at least 4,000 hours of supervised experience in the delivery of services to adults or children with: (i) mental illness, substance use disorder, or emotional disturbance; or (ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance use disorder, and psychotropic medications and side effects; or

(2) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with: (i) mental illness, emotional disturbance, or substance use disorder, and receives treatment supervision as required by applicable statutes and rules from a mental health professional at least once per week until the requirement of 4,000 hours of supervised experience is met; or (ii) traumatic brain injury or developmental disabilities, completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance use disorder, and psychotropic medications and side effects, and receives treatment supervision as required by applicable statutes and rules at least once per week from a mental health professional until the requirement of 4,000 hours of supervised experience is met.

(d) An individual is qualified by a bachelor's or master's degree if the individual: (1) holds a master's or other graduate degree in behavioral sciences or related fields; or (2) holds a bachelor's degree in behavioral sciences or related fields and completes a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.

Subd. 5. **Mental health practitioner scope of practice.** (a) A mental health practitioner must perform services under the treatment supervision of a mental health professional.

(b) A mental health practitioner may perform client education, functional assessments for adult clients, level of care assessments, rehabilitative interventions, and skills building; provide direction to a mental health rehabilitation worker or mental health behavioral aide; and propose individual treatment plans.

(c) A mental health practitioner who provides services according to section 256B.0624 or 256B.0944 may perform crisis assessment and intervention.

Subd. 6. **Clinical trainee qualifications.** (a) A clinical trainee is a staff person who is enrolled in or has completed an accredited graduate program of study intended to prepare the individual for independent licensure as a mental health professional and who: (1) participates in a practicum or internship supervised by a mental health professional; or (2) is completing postgraduate hours, according to the requirements of a health-related licensing board.

(b) A clinical trainee is responsible for notifying and applying to a health-related licensing board to ensure the requirements of the health-related licensing board are met. As permitted by a health-related licensing board, treatment supervision under this chapter may be integrated into a plan to meet the supervisory requirements of the health-related licensing board but does not supersede those requirements.

Subd. 7. **Clinical trainee scope of practice.** (a) A clinical trainee, under treatment supervision of a mental health professional, may perform psychotherapy, diagnostic assessments, and services that a mental health practitioner may deliver. A clinical trainee shall not provide treatment supervision. A clinical trainee may provide direction to a mental health behavioral aide or mental health rehabilitation worker.

(b) A psychological clinical trainee under the treatment supervision of a psychologist may perform psychological testing.

(c) A clinical trainee shall not deliver services in violation of the practice act of a health-related licensing board, including failure to obtain licensure, if required.

Subd. 8. **Certified rehabilitation specialist qualifications.** A certified rehabilitation specialist shall have:

(1) a master's degree from an accredited college or university in behavioral sciences or related fields as defined in section 245I.02, subdivision 3;

(2) at least 4,000 hours of postmaster's supervised experience in the delivery of mental health services; and

(3) a valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner.

Subd. 9. **Certified rehabilitation specialist scope of practice.** A certified rehabilitation specialist shall provide services based on a client's diagnostic assessment. A certified rehabilitation specialist may provide supervision for mental health certified peer specialists,

mental health practitioners, and mental health rehabilitation workers, but is prohibited from performing a diagnostic assessment.

Subd. 10. **Mental health certified peer specialist qualifications.** A mental health certified peer specialist shall:

(1) be 21 years of age or older;

(2) have been diagnosed with a mental illness;

(3) be a current or former mental health services client; and

(4) have a valid certification as a mental health certified peer specialist according to section 245.696, subdivision 3.

Subd. 11. **Mental health certified peer specialist scope of practice.** A mental health certified peer specialist shall:

(1) provide peer support that is individualized to the client;

(2) promote recovery goals, self-sufficiency, self-advocacy, and the development of natural supports; and

(3) support the maintenance of skills learned in other services.

Subd. 12. **Mental health certified family peer specialist qualifications.** A mental health certified family peer specialist shall:

(1) be 21 years of age or older;

(2) have raised or be currently raising a child with a mental illness;

(3) have experience navigating the children's mental health system; and

(4) have a valid certification as a mental health certified family peer specialist according to section 245.696, subdivision 3.

Subd. 13. **Mental health certified family peer specialist scope of practice.** A mental health certified family peer specialist shall provide services to increase the child's ability to function better within the child's home, school, and community. The mental health certified family peer specialist shall:

(1) provide family peer support, to build on strengths of families and help families achieve desired outcomes;

(2) provide nonadversarial advocacy that encourages partnership and promotes positive change and growth;

(3) support families to advocate for culturally appropriate services for a child in each treatment setting;

(4) promote resiliency, self-advocacy, and development of natural supports;

(5) support the maintenance of skills learned in other services;

(6) establish and lead parent support groups;

(7) assist parents to develop coping and problem-solving skills; and

(8) educate parents about mental illnesses and community resources, including resources that connect parents with similar experiences.

Subd. 14. **Mental health rehabilitation worker qualifications.** (a) A mental health rehabilitation worker shall (1) be 21 years of age or older; (2) have a high school diploma or equivalent; and (3) meet the qualification requirements in paragraph (b).

(b) In addition to the requirements of paragraph (a), a mental health rehabilitation worker shall also:

(1) be fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;

(2) have an associate of arts degree;

(3) have two years of full-time postsecondary education or a total of 15 semester hours or 23 quarter hours in behavioral sciences or related fields;

(4) be a registered nurse;

(5) have within the previous ten years three years of personal life experience with mental illness;

(6) have within the previous ten years three years of life experience as a primary caregiver to an adult with a mental illness, traumatic brain injury, substance use disorder, or developmental disability; or

(7) have within the previous ten years 2,000 hours of supervised work experience in delivering mental health services to adults with a mental illness, traumatic brain injury, substance use disorder, or developmental disability.

(c) If the mental health rehabilitation worker provides crisis residential services, intensive residential treatment services, partial hospitalization, or day treatment services, the mental health rehabilitation worker shall: (1) satisfy paragraph (b), clause (1); and (2) have 40 hours

of additional continuing education on mental health topics during the first year of employment.

Subd. 15. **Mental health rehabilitation worker scope of practice.** (a) A mental health rehabilitation worker under supervision of a mental health practitioner or mental health professional may provide rehabilitative mental health services identified in the client's individual treatment plan and individual behavior plan.

(b) A mental health rehabilitation worker who solely acts and is scheduled as overnight staff is exempt from the additional qualification requirements in subdivision 14, paragraphs (a), clause (3), and (b).

Subd. 16. **Mental health behavioral aide qualifications.** (a) A level 1 mental health behavioral aide shall:

(1) be 18 years of age or older; and

(2) have a high school diploma or commissioner of education-selected high school equivalency certification; or two years of experience as a primary caregiver to a child with severe emotional disturbance within the previous ten years.

(b) A level 2 mental health behavioral aide shall:

(1) be 18 years of age or older; and

(2) have an associate or bachelor's degree or be certified by a program under section 256B.0943, subdivision 8a.

Subd. 17. **Mental health behavioral aide scope of practice.** The mental health behavioral aide under supervision of a mental health professional may provide rehabilitative mental health services identified in the client's individual treatment plan and individual behavior plan.

Sec. 45. **[245I.18] TREATMENT SUPERVISION.**

Subdivision 1. **Generally.** (a) A provider entity shall ensure that a mental health professional provides treatment supervision for each staff person who provides services to a client and who is not a mental health professional or certified rehabilitation specialist. Treatment supervision shall be based on a staff person's written treatment supervision plan.

(b) Treatment supervision must focus on the client's treatment needs and the ability of the staff person receiving treatment supervision to provide services, including:

(1) review and evaluation of the interventions delivered;

(2) instruction on alternative strategies if a client is not achieving treatment goals;

(3) review and evaluation of assessments, treatment plans, and progress notes for accuracy and appropriateness;

(4) approval of diagnostic assessments and individual treatment plans within five business days of initial completion by the supervisee;

(5) instruction on the cultural norms or values of the clients and communities served by the provider entity and any impact on treatment;

(6) evaluation of and feedback on the competencies of direct service staff persons; and

(7) coaching, teaching, and practicing skills with staff persons.

(c) A treatment supervisor's responsibility for a supervisee is limited to services provided by the associated provider entity. If a supervisee is employed by multiple provider entities, each entity is responsible for furnishing the necessary treatment supervision.

Subd. 2. **Permitted modalities.** (a) Treatment supervision must be conducted face-to-face, including telemedicine, according to the Minnesota Telemedicine Act, sections 62A.67 to 62A.672.

(b) Treatment supervision may be conducted using individual, small group, or team modalities. "Individual supervision" means one or more mental health professionals and one staff person receiving treatment supervision. "Small group supervision" means one or more mental health professionals and two to six staff persons receiving treatment supervision. "Team supervision" is defined by the service lines for which it may be used.

Subd. 3. **Treatment supervision planning.** (a) A written treatment supervision plan shall be developed by a mental health professional who is qualified to provide treatment supervision and the staff person receiving the treatment supervision. The treatment supervision plan must be completed and implemented within 30 days of a new staff person's employment. The treatment supervision plan must be reviewed and updated at least annually.

(b) The treatment supervision plan must include:

(1) the name and qualifications of the staff person receiving treatment supervision;

(2) the name of the provider entity under which the staff person is receiving treatment supervision;

(3) the name and licensure of a mental health professional providing treatment supervision;

(4) the number of hours of individual and group supervision the staff person receiving treatment supervision must complete and the location of the record if the record is kept outside of an individual personnel file;

(5) procedures that the staff person receiving treatment supervision shall use to respond to client emergencies; and

(6) the authorized scope of practice for the staff person receiving treatment supervision, including a description of responsibilities with the provider entity, a description of client population, and treatment methods and modalities.

Subd. 4. **Treatment supervision record.** (a) A provider entity shall ensure treatment supervision is documented in each staff person's treatment supervision record.

(b) The treatment supervision record must include:

(1) the date and duration of the supervision;

(2) identification of the supervision type as individual, small group, or team supervision;

(3) the name of the mental health professional providing treatment supervision;

(4) subsequent actions that the staff person receiving treatment supervision shall take; and

(5) the date and signature of the mental health professional providing treatment supervision.

Subd. 5. **Supervision and direct observation of mental health rehabilitation workers and behavioral aides.** (a) A mental health practitioner, clinical trainee, or mental health professional shall directly observe a mental health behavioral aide or a mental health rehabilitation worker while the mental health behavioral aide or mental health rehabilitation worker provides services to clients. The amount of direct observation shall be no less than twice per month for the first six months and once per month thereafter. The staff performing the observation shall approve the progress note for the service observed.

(b) For a rehabilitation worker qualified under section 245I.16, subdivision 14, paragraph (b), clause (1), the treatment supervision in the first 2,000 hours of work shall be no less than:

(1) monthly individual treatment supervision; and

(2) twice per month direct observation.

Sec. 46. **[245I.32] CLIENT FILES.**

Subdivision 1. **Generally.** A provider entity must maintain a file of current and accurate client records on the premises where the service is provided or coordinated. Each entry in the record must be signed and dated by the staff person making the entry.

Subd. 2. **Record retention.** A provider entity must retain client records of a discharged client for a minimum of seven years from the date of discharge. A provider entity that ceases to provide treatment service must retain client records for a minimum of seven years from the date the provider entity stopped providing the service and must notify the commissioner of the location of the client records and the name of the individual responsible for maintaining the client records.

Subd. 3. **Contents.** Client files must contain the following, as applicable:

(1) diagnostic assessments;

(2) functional assessments;

(3) individual treatment plans;

(4) individual abuse prevention plans;

(5) crisis plans;

(6) documentation of releases of information;

(7) emergency contacts for the client;

(8) documentation of the date of service; signature of the person providing the service; nature, extent, and units of service; and place of service delivery;

(9) record of all medication prescribed or administered by staff;

(10) documentation of any contact made with the client's other mental health providers, case manager, family members, primary caregiver, or legal representative or the reason the provider did not contact the client's family members or primary caregiver;

(11) documentation of any contact made with other persons interested in the client, including representatives of the courts, corrections systems, or schools;

(12) written information by the client that the client requests be included in the file;

(13) health care directive; and

(14) the date and reason the provider entity's services are discontinued.

Sec. 47. **[245I.33] DOCUMENTATION STANDARDS.**

Subdivision 1. **Generally.** As a condition of payment, a provider entity must ensure that documentation complies with this section and Minnesota Rules, parts 9505.2175 and 9505.2197. The department must recover medical assistance payments for a service not documented in a client file according to this section.

Subd. 2. **Documentation standards.** A provider entity must ensure that all documentation required under this chapter:

(1) is typed or legible, if handwritten;

(2) identifies the client or staff person on each page, as applicable;

(3) is signed and dated by the staff person who completes the documentation, including the staff person's credentials; and

(4) is cosigned and dated by the staff person providing treatment supervision as required under this chapter, including the staff person's credentials.

Subd. 3. **Progress notes.** A provider entity shall use a progress note to promptly document each occurrence of a mental health service provided to a client. A progress note must include the following:

(1) the type of service;

(2) the date of service, including the start and stop time;

(3) the location of service;

(4) the scope of service, including: (i) the goal and objective targeted; (ii) the intervention delivered and the methods used; (iii) the client's response or reaction to intervention; (iv) the plan for the next session; and (v) the service modality;

(5) the signature and the printed name and credentials of the staff person who provided the service;

(6) the mental health provider travel documentation requirements under section 256B.0625, if applicable; and

(7) other significant observations, including (i) current risk factors the client may be experiencing; (ii) emergency interventions; (iii) consultations with or referrals to other professionals, family, or significant others; (iv) a summary of the effectiveness of treatment, prognosis, or discharge planning; (v) test results and medications; or (vi) changes in mental or physical symptoms.

Sec. 48. Minnesota Statutes 2018, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance use disorder services and service enhancements funded under this chapter.

(b) Eligible substance use disorder treatment services include:

(1) outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;

(2) on July 1, 2018, or upon federal approval, whichever is later, comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05~~, and Minnesota Rules, part 9530.6422~~;

(3) on July 1, 2018, or upon federal approval, whichever is later, care coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (6);

(4) on July 1, 2018, or upon federal approval, whichever is later, peer recovery support services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management services provided according to chapter 245F;

(6) medication-assisted therapy services that are licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

(7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;

(8) high, medium, and low intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

(9) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

(10) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

(11) high-intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been

civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

(12) room and board facilities that meet the requirements of subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific programs as defined in section 254B.01, subdivision 4a, or programs or subprograms serving special populations, if the program or subprogram meets the following requirements:

(i) is designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background;

(ii) is governed with significant input from individuals of that specific background; and

(iii) employs individuals to provide individual or group therapy, at least 50 percent of whom are of that specific background, except when the common social background of the individuals served is a traumatic brain injury or cognitive disability and the program employs treatment staff who have the necessary professional training, as approved by the commissioner, to serve clients with the specific disabilities that the program is designed to serve;

(3) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; and

(4) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

(i) the program meets the co-occurring requirements in section 245G.20;

(ii) 25 percent of the counseling staff are licensed mental health professionals~~, as defined in section 245.462, subdivision 18, clauses (1) to (6),~~ qualified according to section 245I.16, subdivision 2, or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and licensed mental health professional, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two; and

(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

(f) Subject to federal approval, chemical dependency services that are otherwise covered as direct face-to-face services may be provided via two-way interactive video. The use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

Sec. 49. Minnesota Statutes 2018, section 256B.0615, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers mental health certified peer specialist services~~, as established in subdivision 2, subject to federal approval, if provided to recipients who are eligible for services under sections 256B.0622, 256B.0623, and 256B.0624 and are~~ provided by a certified peer specialist who ~~has completed the training under subdivision 5~~ is qualified according to section 245I.16, subdivision 10.

Sec. 50. Minnesota Statutes 2018, section 256B.0616, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer specialists services~~, as established in subdivision 2, subject to federal approval, if provided to recipients who have an emotional disturbance or severe emotional disturbance under chapter 245,~~ and are provided by a certified family peer specialist who ~~has completed the training under subdivision 5~~ is qualified according to section 245I.16, subdivision 12. A family peer specialist cannot provide services to the peer specialist's family.

Sec. 51. Minnesota Statutes 2018, section 256B.0616, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** Family peer support services may be ~~located in~~ provided to recipients of inpatient hospitalization, partial hospitalization, residential treatment, intensive treatment in foster care, day treatment, children's therapeutic services and supports, or crisis services.

Sec. 52. Minnesota Statutes 2018, section 256B.0622, subdivision 1, is amended to read:

Subdivision 1. **Scope.** ~~Subject to federal approval,~~ Medical assistance covers medically necessary, assertive community treatment for clients as defined in subdivision 2a and intensive residential treatment services for clients as defined in subdivision 3, when the services are provided by an entity meeting the standards in this section.

Sec. 53. Minnesota Statutes 2018, section 256B.0622, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "ACT team" means the group of interdisciplinary mental health staff who work as a team to provide assertive community treatment.

(c) "Assertive community treatment" means intensive nonresidential treatment and rehabilitative mental health services provided according to the assertive community treatment model. Assertive community treatment provides a single, fixed point of responsibility for

treatment, rehabilitation, and support needs for clients. Services are offered 24 hours per day, seven days per week, in a community-based setting.

~~(d) "Individual treatment plan" means the document that results from a person-centered planning process of determining real-life outcomes with clients and developing strategies to achieve those outcomes.~~

~~(e) "Assertive engagement" means the use of collaborative strategies to engage clients to receive services.~~

~~(f) "Benefits and finance support" means assisting clients in capably managing financial affairs. Services include, but are not limited to, assisting clients in applying for benefits; assisting with redetermination of benefits; providing financial crisis management; teaching and supporting budgeting skills and asset development; and coordinating with a client's representative payee, if applicable.~~

(d) "Clinical trainee" means a staff person qualified according to section 245I.16, subdivision 6.

~~(g)~~ (e) "Co-occurring disorder treatment" means the treatment of co-occurring mental illness and substance use disorders and is characterized by assertive outreach, stage-wise comprehensive treatment, treatment goal setting, and flexibility to work within each stage of treatment. Services include, but are not limited to, assessing and tracking clients' stages of change readiness and treatment; applying the appropriate treatment based on stages of change, such as outreach and motivational interviewing techniques to work with clients in earlier stages of change readiness and cognitive behavioral approaches and relapse prevention to work with clients in later stages of change; and facilitating access to community supports.

~~(h)~~ (f) "Crisis assessment and intervention" means mental health crisis response services as defined in section 256B.0624, subdivision 2, paragraphs (c) to (e).

~~(i) "Employment services" means assisting clients to work at jobs of their choosing. Services must follow the principles of the individual placement and support (IPS) employment model, including focusing on competitive employment; emphasizing individual client preferences and strengths; ensuring employment services are integrated with mental health services; conducting rapid job searches and systematic job development according to client preferences and choices; providing benefits counseling; and offering all services in an individualized and time-unlimited manner. Services shall also include educating clients about opportunities and benefits of work and school and assisting the client in learning job skills, navigating the work place, and managing work relationships.~~

~~(j) "Family psychoeducation and support" means services provided to the client's family and other natural supports to restore and strengthen the client's unique social and family relationships. Services include, but are not limited to, individualized psychoeducation about the client's illness and the role of the family and other significant people in the therapeutic process; family intervention to restore contact, resolve conflict, and maintain relationships with family and other significant people in the client's life; ongoing communication and collaboration between the ACT team and the family; introduction and referral to family self-help programs and advocacy organizations that promote recovery and family engagement, individual supportive counseling, parenting training, and service coordination to help clients fulfill parenting responsibilities; coordinating services for the child and restoring relationships with children who are not in the client's custody; and coordinating with child welfare and family agencies, if applicable. These services must be provided with the client's agreement and consent.~~

~~(k) "Housing access support" means assisting clients to find, obtain, retain, and move to safe and adequate housing of their choice. Housing access support includes, but is not limited to, locating housing options with a focus on integrated independent settings; applying for housing subsidies, programs, or resources; assisting the client in developing relationships with local landlords; providing tenancy support and advocacy for the individual's tenancy rights at the client's home; and assisting with relocation.~~

(g) "Individual treatment plan" means a plan described under section 256B.0671, subdivisions 5 and 6.

~~(l)~~ (h) "Individual treatment team" means a minimum of three members of the ACT team who are responsible for consistently carrying out most of a client's assertive community treatment services.

~~(m)~~ (i) "Intensive residential treatment services treatment team" means all staff who provide intensive residential treatment services under this section to clients. ~~At a minimum, this includes the clinical supervisor; mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (6); mental health practitioners as defined in section 245.462, subdivision 17; mental health rehabilitation workers under section 256B.0623, subdivision 5, paragraph (a), clause (4); and mental health certified peer specialists under section 256B.0615.~~

~~(n)~~ (j) "Intensive residential treatment services" means short-term, time-limited services provided in a residential setting to clients who are in need of more restrictive settings and are at risk of significant functional deterioration if they do not receive these services. Services

are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more independent setting. Services must be directed toward a targeted discharge date with specified client outcomes.

~~(o) "Medication assistance and support" means assisting clients in accessing medication, developing the ability to take medications with greater independence, and providing medication setup. This includes the prescription, administration, and order of medication by appropriate medical staff.~~

~~(p) "Medication education" means educating clients on the role and effects of medications in treating symptoms of mental illness and the side effects of medications.~~

(k) "Mental health certified peer specialist" means a staff person qualified according to section 245I.16, subdivision 10.

(l) "Mental health practitioner" means a staff person qualified according to section 245I.16, subdivision 4.

(m) "Mental health professional" means a staff person qualified according to section 245I.16, subdivision 2.

(n) "Mental health rehabilitation worker" means a staff person qualified according to section 245I.16, subdivision 14.

~~(q)~~ (o) "Overnight staff" means a member of the intensive residential treatment services team who is responsible during hours when clients are typically asleep.

~~(r) "Mental health certified peer specialist services" has the meaning given in section 256B.0615.~~

~~(s)~~ (p) "Physical health services" means any service or treatment to meet the physical health needs of the client to support the client's mental health recovery. Services include, but are not limited to, education on primary health issues, including wellness education; medication administration and monitoring; providing and coordinating medical screening and follow-up; scheduling routine and acute medical and dental care visits; tobacco cessation strategies; assisting clients in attending appointments; communicating with other providers; and integrating all physical and mental health treatment.

~~(t)~~ (q) "Primary team member" means the person who leads and coordinates the activities of the individual treatment team and is the individual treatment team member who has primary responsibility for establishing and maintaining a therapeutic relationship with the client on a continuing basis.

~~(u)~~ (r) "Rehabilitative mental health services" means mental health services that are rehabilitative and enable the client to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, independent living, parenting skills, and community skills, when these abilities are impaired by the symptoms of mental illness.

~~(v)~~ (s) "Symptom management" means supporting clients in identifying and targeting the symptoms and occurrence patterns of their mental illness and developing strategies to reduce the impact of those symptoms.

~~(w)~~ (t) "Therapeutic interventions" means empirically supported techniques to address specific symptoms and behaviors such as anxiety, psychotic symptoms, emotional dysregulation, and trauma symptoms. Interventions include empirically supported psychotherapies including, but not limited to, cognitive behavioral therapy, exposure therapy, acceptance and commitment therapy, interpersonal therapy, and motivational interviewing.

~~(x)~~ (u) "Wellness self-management and prevention" means a combination of approaches to working with the client to build and apply skills related to recovery, and to support the client in participating in leisure and recreational activities, civic participation, and meaningful structure.

Sec. 54. Minnesota Statutes 2018, section 256B.0622, subdivision 3a, is amended to read:

Subd. 3a. **Provider certification and contract requirements for assertive community treatment.** (a) The assertive community treatment provider must:

(1) have a contract with the host county to provide assertive community treatment services; and

(2) have each ACT team be certified by the state following the certification process and procedures developed by the commissioner. The certification process determines whether the ACT team meets the standards for assertive community treatment under this section ~~as well as~~, chapter 245I, and minimum program fidelity standards as measured by a nationally recognized fidelity tool approved by the commissioner. Recertification must occur at least every three years.

(b) An ACT team certified under this subdivision must meet the following standards:

(1) have capacity to recruit, hire, manage, and train required ACT team members;

(2) have adequate administrative ability to ensure availability of services;

~~(3) ensure adequate preservice and ongoing training for staff;~~

~~(4) ensure that staff is capable of implementing culturally specific services that are culturally responsive and appropriate as determined by the client's culture, beliefs, values, and language as identified in the individual treatment plan;~~

~~(5)~~ (3) ensure flexibility in service delivery to respond to the changing and intermittent care needs of a client as identified by the client and the individual treatment plan;

~~(6) develop and maintain client files, individual treatment plans, and contact charting;~~

~~(7) develop and maintain staff training and personnel files;~~

~~(8)~~ (4) submit information as required by the state;

~~(9)~~ (5) keep all necessary records required by law;

~~(10) comply with all applicable laws;~~

~~(11)~~ (6) be an enrolled Medicaid provider;

~~(12)~~ (7) establish and maintain a quality assurance plan to determine specific service outcomes and the client's satisfaction with services; and

~~(13)~~ (8) develop and maintain written policies and procedures regarding service provision and administration of the provider entity.

(c) The commissioner may intervene at any time and decertify an ACT team with cause. The commissioner shall establish a process for decertification of an ACT team and shall require corrective action, medical assistance repayment, or decertification of an ACT team that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process. The decertification is subject to appeal to the state.

Sec. 55. Minnesota Statutes 2018, section 256B.0622, subdivision 4, is amended to read:

Subd. 4. **Provider entity licensure and contract requirements for intensive residential treatment services.** (a) The intensive residential treatment services provider entity must:

(1) be licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;

(2) not exceed 16 beds per site; and

(3) comply with the additional standards in this section and chapter 245I.

(b) The commissioner shall develop procedures for counties and providers to submit other documentation as needed to allow the commissioner to determine whether the standards in this section are met.

(c) A provider entity must specify in the provider entity's application what geographic area and populations will be served by the proposed program. A provider entity must document that the capacity or program specialties of existing programs are not sufficient to meet the service needs of the target population. A provider entity must submit evidence of ongoing relationships with other providers and levels of care to facilitate referrals to and from the proposed program.

(d) A provider entity must submit documentation that the provider entity requested a statement of need from each county board and tribal authority that serves as a local mental health authority in the proposed service area. The statement of need must specify if the local mental health authority supports or does not support the need for the proposed program and the basis for this determination. If a local mental health authority does not respond within 60 days of the receipt of the request, the commissioner shall determine the need for the program based on the documentation submitted by the provider entity.

Sec. 56. Minnesota Statutes 2018, section 256B.0622, subdivision 5a, is amended to read:

Subd. 5a. **Standards for intensive residential rehabilitative mental health services.** (a) The standards in this subdivision apply to intensive residential mental health services.

(b) The provider of intensive residential treatment services must have sufficient staff to provide 24-hour-per-day coverage to deliver the rehabilitative services described in the treatment plan and to safely supervise and direct the activities of clients, given the client's level of behavioral and psychiatric stability, cultural needs, and vulnerability. The provider must have the capacity within the facility to provide integrated services for chemical dependency, illness management services, and family education, when appropriate.

(c) At a minimum:

(1) staff must provide direction and supervision whenever clients are present in the facility;

(2) staff must remain awake during all work hours;

(3) there must be a staffing ratio of at least one to nine clients for each day and evening shift. If more than nine clients are present at the residential site, there must be a minimum of two staff during day and evening shifts, one of whom must be a mental health practitioner or mental health professional;

(4) if services are provided to clients who need the services of a medical professional, the provider shall ensure that these services are provided either by the provider's own medical staff or through referral to a medical professional; and

(5) the provider must ensure the timely availability of a licensed registered nurse, either directly employed or under contract, who is responsible for ensuring the effectiveness and safety of medication administration in the facility and assessing clients for medication side effects and drug interactions.

(d) Services must be provided by qualified staff as defined in section 256B.0623, subdivision 5~~, who are trained and supervised according to section 256B.0623, subdivision 6, except that mental health rehabilitation workers acting as overnight staff are not required to comply with section 256B.0623, subdivision 5, paragraph (a), clause (4), item (iv)~~.

(e) The ~~clinical~~ treatment supervisor must be an active member of the intensive residential services treatment team. The team must meet with the ~~clinical~~ treatment supervisor at least weekly to discuss clients' progress and make rapid adjustments to meet clients' needs. The team meeting shall include client-specific case reviews and general treatment discussions among team members. Client-specific case reviews and planning must be documented in the client's treatment record.

(f) Treatment staff must have prompt access in person or by telephone to a mental health practitioner or mental health professional. The provider must have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to ensure the health and safety of clients.

(g) The initial functional assessment must be completed within ten days of intake and updated at least every 30 days, or prior to discharge from the service, whichever comes first.

(h) The initial individual treatment plan must be completed within 24 hours of admission. Within ten days of admission, the initial treatment plan must be refined and further developed, except for providers certified according to Minnesota Rules, parts 9533.0010 to 9533.0180. The individual treatment plan must be reviewed with the client and updated at least monthly.

Sec. 57. Minnesota Statutes 2018, section 256B.0622, subdivision 7, is amended to read:

Subd. 7. **Assertive community treatment service standards.** (a) ACT teams must offer and have the capacity to directly provide the following services:

(1) assertive engagement using collaborative strategies to encourage clients to receive services;

(2) benefits and finance support~~;~~ that assists clients to capably manage financial affairs. Services include but are not limited to assisting clients in applying for benefits, assisting with redetermination of benefits, providing financial crisis management, teaching and

supporting budgeting skills and asset development, and coordinating with a client's representative payee, if applicable;

(3) co-occurring disorder treatment;

(4) crisis assessment and intervention;

(5) employment services; that assists clients to work at jobs of their choosing. Services must follow the principles of the individual placement and support employment model, including focusing on competitive employment, emphasizing individual client preferences and strengths, ensuring employment services are integrated with mental health services, conducting rapid job searches and systematic job development according to client preferences and choices, providing benefits counseling, and offering all services in an individualized and time-unlimited manner. Services must also include educating clients about opportunities and benefits of work and school and assisting the client in learning job skills, navigating the workplace, workplace accommodations, and managing work relationships;

(6) family psychoeducation and support; provided to the client's family and other natural supports to restore and strengthen the client's unique social and family relationships. Services include but are not limited to individualized psychoeducation about the client's illness and the role of the family and other significant people in the therapeutic process; family intervention to restore contact, resolve conflict, and maintain relationships with family and other significant people in the client's life; ongoing communication and collaboration between the ACT team and the family; introduction and referral to family self-help programs and advocacy organizations that promote recovery and family engagement, individual supportive counseling, parenting training, and service coordination to help clients fulfill parenting responsibilities; coordinating services for the child and restoring relationships with children who are not in the client's custody; and coordinating with child welfare and family agencies, if applicable. These services must be provided with the client's agreement and consent;

(7) housing access support; that assists clients to find, obtain, retain, and move to safe and adequate housing of their choice. Housing access support includes but is not limited to locating housing options with a focus on integrated independent settings; applying for housing subsidies, programs, or resources; assisting the client in developing relationships with local landlords; providing tenancy support and advocacy for the individual's tenancy rights at the client's home; and assisting with relocation;

(8) medication assistance and support; that assists clients in accessing medication, developing the ability to take medications with greater independence, and providing

medication setup. Medication assistance and support includes assisting the client with the prescription, administration, and ordering of medication by appropriate medical staff;

(9) medication education~~;~~ that educates clients on the role and effects of medications in treating symptoms of mental illness and the side effects of medications;

(10) mental health certified peer specialists services;

(11) physical health services;

(12) rehabilitative mental health services;

(13) symptom management;

(14) therapeutic interventions;

(15) wellness self-management and prevention; and

(16) other services based on client needs as identified in a client's assertive community treatment individual treatment plan.

(b) ACT teams must ensure the provision of all services necessary to meet a client's needs as identified in the client's individual treatment plan.

Sec. 58. Minnesota Statutes 2018, section 256B.0622, subdivision 7a, is amended to read:

Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a) The required treatment staff qualifications and roles for an ACT team are:

(1) the team leader:

(i) shall be a ~~licensed~~ mental health professional ~~who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A~~. Individuals who are not licensed but who are eligible for licensure and are otherwise qualified may also fulfill this role but must obtain full licensure within 24 months of assuming the role of team leader;

(ii) must be an active member of the ACT team and provide some direct services to clients;

(iii) must be a single full-time staff member, dedicated to the ACT team, who is responsible for overseeing the administrative operations of the team, providing ~~clinical oversight~~ treatment supervision of services in conjunction with the psychiatrist or psychiatric care provider, and supervising team members to ensure delivery of best and ethical practices; and

(iv) must be available to provide overall ~~clinical oversight~~ treatment supervision to the ACT team after regular business hours and on weekends and holidays. The team leader may delegate this duty to another qualified member of the ACT team;

(2) the psychiatric care provider:

(i) must be a ~~licensed psychiatrist certified by the American Board of Psychiatry and Neurology or eligible for board certification or certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification, or a psychiatric nurse who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A~~ mental health professional permitted to prescribe psychiatric medications as part of the professional's scope of practice. The psychiatric care provider must have demonstrated clinical experience working with individuals with serious and persistent mental illness;

(ii) shall collaborate with the team leader in sharing overall clinical responsibility for screening and admitting clients; monitoring clients' treatment and team member service delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects, and health-related conditions; actively collaborating with nurses; and helping provide ~~clinical~~ treatment supervision to the team;

(iii) shall fulfill the following functions for assertive community treatment clients: provide assessment and treatment of clients' symptoms and response to medications, including side effects; provide brief therapy to clients; provide diagnostic and medication education to clients, with medication decisions based on shared decision making; monitor clients' nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and community visits;

(iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized for mental health treatment and shall communicate directly with the client's inpatient psychiatric care providers to ensure continuity of care;

(v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per 50 clients. Part-time psychiatric care providers shall have designated hours to work on the team, with sufficient blocks of time on consistent days to carry out the provider's clinical, supervisory, and administrative responsibilities. No more than two psychiatric care providers may share this role;

(vi) may not provide specific roles and responsibilities by telemedicine unless approved by the commissioner; and

(vii) shall provide psychiatric backup to the program after regular business hours and on weekends and holidays. The psychiatric care provider may delegate this duty to another qualified psychiatric provider;

(3) the nursing staff:

(i) shall consist of one to three registered nurses or advanced practice registered nurses, of whom at least one has a minimum of one-year experience working with adults with serious mental illness and a working knowledge of psychiatric medications. No more than two individuals can share a full-time equivalent position;

(ii) are responsible for managing medication, administering and documenting medication treatment, and managing a secure medication room; and

(iii) shall develop strategies, in collaboration with clients, to maximize taking medications as prescribed; screen and monitor clients' mental and physical health conditions and medication side effects; engage in health promotion, prevention, and education activities; communicate and coordinate services with other medical providers; facilitate the development of the individual treatment plan for clients assigned; and educate the ACT team in monitoring psychiatric and physical health symptoms and medication side effects;

(4) the co-occurring disorder specialist:

(i) shall be a full-time equivalent co-occurring disorder specialist who has received specific training on co-occurring disorders that is consistent with national evidence-based practices. The training must include practical knowledge of common substances and how they affect mental illnesses, the ability to assess substance use disorders and the client's stage of treatment, motivational interviewing, and skills necessary to provide counseling to clients at all different stages of change and treatment. The co-occurring disorder specialist may also be an individual who is a licensed alcohol and drug counselor as described in section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience, and other requirements in section 245G.11, subdivision 5. No more than two co-occurring disorder specialists may occupy this role; and

(ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients. The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT team members on co-occurring disorders;

(5) the vocational specialist:

(i) shall be a full-time vocational specialist who has at least one-year experience providing employment services or advanced education that involved field training in vocational services

to individuals with mental illness. An individual who does not meet these qualifications may also serve as the vocational specialist upon completing a training plan approved by the commissioner;

(ii) shall provide or facilitate the provision of vocational services to clients. The vocational specialist serves as a consultant and educator to fellow ACT team members on these services; and

(iii) ~~should~~ shall not refer individuals to receive any type of vocational services or linkage by providers outside of the ACT team;

(6) the mental health certified peer specialist:

(i) shall be a full-time equivalent ~~mental health certified peer specialist as defined in section 256B.0615~~. No more than two individuals can share this position. The mental health certified peer specialist is a fully integrated team member who provides highly individualized services in the community and promotes the self-determination and shared decision-making abilities of clients. This requirement may be waived due to workforce shortages upon approval of the commissioner;

(ii) must provide coaching, mentoring, and consultation to the clients to promote recovery, self-advocacy, and self-direction, promote wellness management strategies, and assist clients in developing advance directives; and

(iii) must model recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience, provide consultation to team members, promote a culture where the clients' points of view and preferences are recognized, understood, respected, and integrated into treatment, and serve in a manner equivalent to other team members;

(7) the program administrative assistant shall be a full-time office-based program administrative assistant position assigned to solely work with the ACT team, providing a range of supports to the team, clients, and families; and

(8) additional staff:

(i) shall be based on team size. Additional treatment team staff may include ~~licensed~~ mental health professionals ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item A~~; mental health practitioners ~~as defined in section 245.462, subdivision 17; a mental health practitioner working as a~~; clinical ~~trainee according to Minnesota Rules, part 9505.0371, subpart 5, item C~~ trainees; or mental health rehabilitation workers ~~as defined in section 256B.0623, subdivision 5, paragraph (a), clause (4)~~. These individuals shall have the

knowledge, skills, and abilities required by the population served to carry out rehabilitation and support functions; and

(ii) shall be selected based on specific program needs or the population served.

(b) Each ACT team must clearly document schedules for all ACT team members.

(c) Each ACT team member must serve as a primary team member for clients assigned by the team leader and are responsible for facilitating the individual treatment plan process for those clients. The primary team member for a client is the responsible team member knowledgeable about the client's life and circumstances and writes the individual treatment plan. The primary team member provides individual supportive therapy or counseling, and provides primary support and education to the client's family and support system.

(d) Members of the ACT team must have strong clinical skills, professional qualifications, experience, and competency to provide a full breadth of rehabilitation services. Each staff member shall be proficient in their respective discipline and be able to work collaboratively as a member of a multidisciplinary team to deliver the majority of the treatment, rehabilitation, and support services clients require to fully benefit from receiving assertive community treatment.

(e) Each ACT team member must fulfill training requirements established by the commissioner.

Sec. 59. Minnesota Statutes 2018, section 256B.0622, subdivision 7b, is amended to read:

Subd. 7b. **Assertive community treatment program size and opportunities.** (a) Each ACT team shall maintain an annual average caseload that does not exceed 100 clients. Staff-to-client ratios shall be based on team size as follows:

(1) a small ACT team must:

(i) employ at least six but no more than seven full-time treatment team staff, excluding the program assistant and the psychiatric care provider;

(ii) serve an annual average maximum of no more than 50 clients;

(iii) ensure at least one full-time equivalent position for every eight clients served;

(iv) schedule ACT team staff for at least eight-hour shift coverage on weekdays and on-call duty to provide crisis services and deliver services after hours when staff are not working;

(v) provide crisis services during business hours if the small ACT team does not have sufficient staff numbers to operate an after-hours on-call system. During all other hours, the ACT team may arrange for coverage for crisis assessment and intervention services through a reliable crisis-intervention provider as long as there is a mechanism by which the ACT team communicates routinely with the crisis-intervention provider and the on-call ACT team staff are available to see clients face-to-face when necessary or if requested by the crisis-intervention services provider;

(vi) adjust schedules and provide staff to carry out the needed service activities in the evenings or on weekend days or holidays, when necessary;

(vii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the ACT team's psychiatric care provider during all hours is not feasible, alternative psychiatric prescriber backup must be arranged and a mechanism of timely communication and coordination established in writing; and

(viii) be composed of, at minimum, one full-time team leader, at least 16 hours each week per 50 clients of psychiatric provider time, or equivalent if fewer clients, one full-time equivalent nursing, one full-time substance abuse specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least one additional full-time ACT team member who has mental health professional, clinical trainee, or mental health practitioner status; and

(2) a midsize ACT team shall:

(i) be composed of, at minimum, one full-time team leader, at least 16 hours of psychiatry time for 51 clients, with an additional two hours for every six clients added to the team, 1.5 to two full-time equivalent nursing staff, one full-time substance abuse specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least 1.5 to two additional full-time equivalent ACT members, with at least one dedicated full-time staff member with mental health professional status. Remaining team members may have mental health professional, clinical trainee, or mental health practitioner status;

(ii) employ seven or more treatment team full-time equivalents, excluding the program assistant and the psychiatric care provider;

(iii) serve an annual average maximum caseload of 51 to 74 clients;

(iv) ensure at least one full-time equivalent position for every nine clients served;

(v) schedule ACT team staff for a minimum of ten-hour shift coverage on weekdays and six- to eight-hour shift coverage on weekends and holidays. In addition to these minimum specifications, staff are regularly scheduled to provide the necessary services on a client-by-client basis in the evenings and on weekends and holidays;

(vi) schedule ACT team staff on-call duty to provide crisis services and deliver services when staff are not working;

(vii) have the authority to arrange for coverage for crisis assessment and intervention services through a reliable crisis-intervention provider as long as there is a mechanism by which the ACT team communicates routinely with the crisis-intervention provider and the on-call ACT team staff are available to see clients face-to-face when necessary or if requested by the crisis-intervention services provider; and

(viii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the psychiatric care provider during all hours is not feasible, alternative psychiatric prescriber backup must be arranged and a mechanism of timely communication and coordination established in writing;

(3) a large ACT team must:

(i) be composed of, at minimum, one full-time team leader, at least 32 hours each week per 100 clients, or equivalent of psychiatry time, three full-time equivalent nursing staff, one full-time substance abuse specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least two additional full-time equivalent ACT team members, with at least one dedicated full-time staff member with mental health professional status. Remaining team members may have mental health professional, clinical trainee, or mental health practitioner status;

(ii) employ nine or more treatment team full-time equivalents, excluding the program assistant and psychiatric care provider;

(iii) serve an annual average maximum caseload of 75 to 100 clients;

(iv) ensure at least one full-time equivalent position for every nine individuals served;

(v) schedule staff to work two eight-hour shifts, with a minimum of two staff on the second shift providing services at least 12 hours per day weekdays. For weekends and holidays, the team must operate and schedule ACT team staff to work one eight-hour shift, with a minimum of two staff each weekend day and every holiday;

(vi) schedule ACT team staff on-call duty to provide crisis services and deliver services when staff are not working; and

(vii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the ACT team psychiatric care provider during all hours is not feasible, alternative psychiatric backup must be arranged and a mechanism of timely communication and coordination established in writing.

(b) An ACT team of any size may have a staff-to-client ratio that is lower than the requirements described in paragraph (a) upon approval by the commissioner, but may not exceed a one-to-ten staff-to-client ratio.

Sec. 60. Minnesota Statutes 2018, section 256B.0622, subdivision 7d, is amended to read:

Subd. 7d. **Assertive community treatment assessment and individual treatment plan.** (a) An initial assessment, including a diagnostic assessment that meets the requirements of ~~Minnesota Rules, part 9505.0372, subpart 1,~~ section 256B.0671, subdivisions 2 and 3, and a 30-day treatment plan shall be completed the day of the client's admission to assertive community treatment by the ACT team leader or the psychiatric care provider, with participation by designated ACT team members and the client. The team leader, psychiatric care provider, or other mental health professional designated by the team leader or psychiatric care provider, must update the client's diagnostic assessment at least annually.

(b) An initial functional assessment must be completed within ten days of intake and updated every six months for assertive community treatment, or prior to discharge from the service, whichever comes first.

(c) Within 30 days of the client's assertive community treatment admission, the ACT team shall complete an in-depth assessment of the domains listed under section 245.462, subdivision 11a.

(d) Each part of the in-depth assessment areas shall be completed by each respective team specialist or an ACT team member with skill and knowledge in the area being assessed. The assessments are based upon all available information, including that from client interview family and identified natural supports, and written summaries from other agencies, including police, courts, county social service agencies, outpatient facilities, and inpatient facilities, where applicable.

(e) Between 30 and 45 days after the client's admission to assertive community treatment, the entire ACT team must hold a comprehensive case conference, where all team members, including the psychiatric provider, present information discovered from the completed in-depth assessments and provide treatment recommendations. The conference must serve

as the basis for the first six-month treatment plan, which must be written by the primary team member.

(f) The client's psychiatric care provider, primary team member, and individual treatment team members shall assume responsibility for preparing the written narrative of the results from the psychiatric and social functioning history timeline and the comprehensive assessment.

(g) The primary team member and individual treatment team members shall be assigned by the team leader in collaboration with the psychiatric care provider by the time of the first treatment planning meeting or 30 days after admission, whichever occurs first.

(h) Individual treatment plans must be developed through the following treatment planning process:

(1) The individual treatment plan shall be developed in collaboration with the client and the client's preferred natural supports, and guardian, if applicable and appropriate. The ACT team shall evaluate, together with each client, the client's needs, strengths, and preferences and develop the individual treatment plan collaboratively. The ACT team shall make every effort to ensure that the client and the client's family and natural supports, with the client's consent, are in attendance at the treatment planning meeting, are involved in ongoing meetings related to treatment, and have the necessary supports to fully participate. The client's participation in the development of the individual treatment plan shall be documented.

(2) The client and the ACT team shall work together to formulate and prioritize the issues, set goals, research approaches and interventions, and establish the plan. The plan is individually tailored so that the treatment, rehabilitation, and support approaches and interventions achieve optimum symptom reduction, help fulfill the personal needs and aspirations of the client, take into account the cultural beliefs and realities of the individual, and improve all the aspects of psychosocial functioning that are important to the client. The process supports strengths, rehabilitation, and recovery.

(3) Each client's individual treatment plan shall identify service needs, strengths and capacities, and barriers, and set specific and measurable short- and long-term goals for each service need. The individual treatment plan must clearly specify the approaches and interventions necessary for the client to achieve the individual goals, when the interventions shall happen, and identify which ACT team member shall carry out the approaches and interventions.

(4) The primary team member and the individual treatment team, together with the client and the client's family and natural supports with the client's consent, are responsible for

reviewing and rewriting the treatment goals and individual treatment plan whenever there is a major decision point in the client's course of treatment or at least every six months.

(5) The primary team member shall prepare a summary that thoroughly describes in writing the client's and the individual treatment team's evaluation of the client's progress and goal attainment, the effectiveness of the interventions, and the satisfaction with services since the last individual treatment plan. The client's most recent diagnostic assessment must be included with the treatment plan summary.

(6) The individual treatment plan and review must be ~~signed~~ approved or acknowledged by the client, the primary team member, the team leader, the psychiatric care provider, and all individual treatment team members. A copy of the ~~signed~~ individual treatment plan is made available to the client.

Sec. 61. Minnesota Statutes 2018, section 256B.0623, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers adult rehabilitative mental health services as defined in subdivision 2, ~~subject to federal approval,~~ if provided to recipients as defined in subdivision 3 and provided by a qualified provider entity meeting the standards in this section and by a qualified individual provider working within the provider's scope of practice and identified in the recipient's individual treatment plan ~~as defined~~ described in section ~~245.462, subdivision 14~~ 256B.0671, subdivisions 5 and 6, and if determined to be medically necessary according to section 62Q.53.

Sec. 62. Minnesota Statutes 2018, section 256B.0623, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Adult rehabilitative mental health services" means mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, independent living, parenting skills, and community skills, when these abilities are impaired by the symptoms of mental illness. ~~Adult rehabilitative mental health services are also appropriate when provided to enable a recipient to retain stability and functioning, if the recipient would be at risk of significant functional decompensation or more restrictive service settings without these services.~~

~~(1) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting~~

~~and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, parenting skills, and transition to community living services.~~

~~(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's home or another community setting or in groups.~~

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, physician assistants, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program under Minnesota Rules, chapter 9505, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

Sec. 63. Minnesota Statutes 2018, section 256B.0623, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is diagnosed with a medical condition, such as mental illness or traumatic brain injury, for which adult rehabilitative mental health services are needed;

(3) has substantial disability and functional impairment in three or more of the areas listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced; and

(4) has had a recent diagnostic assessment ~~or an adult diagnostic assessment update~~ by a qualified professional that documents adult rehabilitative mental health services are medically necessary to address identified disability and functional impairments and individual recipient goals.

Sec. 64. Minnesota Statutes 2018, section 256B.0623, subdivision 4, is amended to read:

Subd. 4. **Provider entity standards.** (a) The provider entity must be certified by the state following the certification process and procedures developed by the commissioner.

(b) The certification process is a determination as to whether the entity meets the standards in this subdivision and chapter 245I. The certification must specify which adult rehabilitative mental health services the entity is qualified to provide.

(c) A noncounty provider entity must obtain additional certification from each county in which it will provide services. The additional certification must be based on the adequacy of the entity's knowledge of that county's local health and human service system, and the ability of the entity to coordinate its services with the other services available in that county. A county-operated entity must obtain this additional certification from any other county in which it will provide services.

(d) State-level recertification must occur at least every three years.

(e) The commissioner may intervene at any time and decertify providers with cause. The decertification is subject to appeal to the state. A county board may recommend that the state decertify a provider for cause.

(f) The adult rehabilitative mental health services provider entity must meet the following standards:

(1) have capacity to recruit, hire, manage, and train ~~mental health professionals, mental health practitioners, and mental health rehabilitation workers~~ qualified staff;

(2) have adequate administrative ability to ensure availability of services;

~~(3) ensure adequate preservice and inservice and ongoing training for staff;~~

~~(4)~~ (3) ensure that ~~mental health professionals, mental health practitioners, and mental health rehabilitation workers~~ staff are skilled in the delivery of the specific adult rehabilitative mental health services provided to the individual eligible recipient;

~~(5) ensure that staff is capable of implementing culturally specific services that are culturally competent and appropriate as determined by the recipient's culture, beliefs, values, and language as identified in the individual treatment plan;~~

~~(6)~~ (4) ensure enough flexibility in service delivery to respond to the changing and intermittent care needs of a recipient as identified by the recipient and the individual treatment plan;

~~(7) ensure that the mental health professional or mental health practitioner, who is under the clinical supervision of a mental health professional, involved in a recipient's services participates in the development of the individual treatment plan;~~

~~(8)~~ (5) assist the recipient in arranging needed crisis assessment, intervention, and stabilization services;

~~(9)~~ (6) ensure that services are coordinated with other recipient mental health services providers and the county mental health authority and the federally recognized American Indian authority and necessary others after obtaining the consent of the recipient. Services must also be coordinated with the recipient's case manager or care coordinator if the recipient is receiving case management or care coordination services;

~~(10) develop and maintain recipient files, individual treatment plans, and contact charting;~~

~~(11) develop and maintain staff training and personnel files;~~

~~(12)~~ (7) submit information as required by the state;

~~(13) establish and maintain a quality assurance plan to evaluate the outcome of services provided;~~

~~(14)~~ (8) keep all necessary records required by law;

~~(15)~~ (9) deliver services as required by section 245.461;

~~(16) comply with all applicable laws;~~

~~(17)~~ (10) be an enrolled Medicaid provider;

~~(18)~~ (11) maintain a quality assurance plan to determine specific service outcomes and the recipient's satisfaction with services; and

~~(19)~~ (12) develop and maintain written policies and procedures regarding service provision and administration of the provider entity.

Sec. 65. Minnesota Statutes 2018, section 256B.0623, subdivision 5, is amended to read:

Subd. 5. **Qualifications of provider staff.** ~~(a)~~ Adult rehabilitative mental health services must be provided by qualified individual provider staff of a certified provider entity. Individual provider staff must be qualified ~~under~~ as one of the following ~~criteria~~ providers:

(1) a mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6). If the recipient has a current diagnostic assessment by a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), recommending receipt of adult mental health rehabilitative services, the definition of mental health professional for purposes of this section includes a person who is qualified under section 245.462, subdivision 18, clause (7), and who holds a current and valid national certification~~

~~as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner~~ qualified according to section 245I.16, subdivision 2;

(2) a certified rehabilitation specialist qualified according to section 245I.16, subdivision 8;

(3) a clinical trainee qualified according to section 245I.16, subdivision 6;

~~(2)~~ (4) a mental health practitioner ~~as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional~~ qualified according to section 245I.16, subdivision 4;

~~(3)~~ (5) a mental health certified peer specialist ~~under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional~~ qualified according to section 245I.16, subdivision 10; or

~~(4)~~ (6) a mental health rehabilitation worker qualified according to section 245I.16, subdivision 14. ~~A mental health rehabilitation worker means a staff person working under the direction of a mental health practitioner or mental health professional and under the clinical supervision of a mental health professional in the implementation of rehabilitative mental health services as identified in the recipient's individual treatment plan who:~~

~~(i) is at least 21 years of age;~~

~~(ii) has a high school diploma or equivalent;~~

~~(iii) has successfully completed 30 hours of training during the two years immediately prior to the date of hire, or before provision of direct services, in all of the following areas: recovery from mental illness, mental health de-escalation techniques, recipient rights, recipient-centered individual treatment planning, behavioral terminology, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, recipient confidentiality; and~~

~~(iv) meets the qualifications in paragraph (b).~~

~~(b) In addition to the requirements in paragraph (a), a mental health rehabilitation worker must also meet the qualifications in clause (1), (2), or (3):~~

~~(1) has an associates of arts degree, two years of full-time postsecondary education, or a total of 15 semester hours or 23 quarter hours in behavioral sciences or related fields; is a registered nurse; or within the previous ten years has:~~

~~(i) three years of personal life experience with serious mental illness;~~

~~(ii) three years of life experience as a primary caregiver to an adult with a serious mental illness, traumatic brain injury, substance use disorder, or developmental disability; or~~

~~(iii) 2,000 hours of supervised work experience in the delivery of mental health services to adults with a serious mental illness, traumatic brain injury, substance use disorder, or developmental disability;~~

~~(2)(i) is fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;~~

~~(ii) receives during the first 2,000 hours of work, monthly documented individual clinical supervision by a mental health professional;~~

~~(iii) has 18 hours of documented field supervision by a mental health professional or mental health practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year;~~

~~(iv) has review and cosignature of charting of recipient contacts during field supervision by a mental health professional or mental health practitioner; and~~

~~(v) has 15 hours of additional continuing education on mental health topics during the first year of employment and 15 hours during every additional year of employment; or~~

~~(3) for providers of crisis residential services, intensive residential treatment services, partial hospitalization, and day treatment services:~~

~~(i) satisfies clause (2), items (ii) to (iv); and~~

~~(ii) has 40 hours of additional continuing education on mental health topics during the first year of employment.~~

~~(c) A mental health rehabilitation worker who solely acts and is scheduled as overnight staff is not required to comply with paragraph (a), clause (4), item (iv).~~

~~(d) For purposes of this subdivision, "behavioral sciences or related fields" means an education from an accredited college or university and includes but is not limited to social work, psychology, sociology, community counseling, family social science, child development, child psychology, community mental health, addiction counseling, counseling and guidance, special education, and other fields as approved by the commissioner.~~

Sec. 66. Minnesota Statutes 2018, section 256B.0623, subdivision 6, is amended to read:

Subd. 6. **Required training and supervision.** (a) ~~Mental health rehabilitation workers must receive ongoing continuing education training of at least 30 hours every two years in~~

~~areas of mental illness and mental health services and other areas specific to the population being served. Mental health rehabilitation workers must also be subject to the ongoing direction and clinical supervision standards in paragraphs (c) and (d)~~ Staff must receive training in accordance with section 245I.10.

~~(b) Mental health practitioners must receive ongoing continuing education training as required by their professional license; or if the practitioner is not licensed, the practitioner must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services. Mental health practitioners must meet the ongoing clinical supervision standards in paragraph (c).~~

~~(c) Clinical supervision may be provided by a full- or part-time qualified professional employed by or under contract with the provider entity. Clinical supervision may be provided by interactive videoconferencing according to procedures developed by the commissioner.~~ (b) Treatment supervision must be provided according to section 245I.18. A mental health professional providing ~~clinical~~ treatment supervision of staff delivering adult rehabilitative mental health services must provide the following guidance:

~~(1) review the information in the recipient's file;~~

~~(2) review and approve initial and updates of individual treatment plans;~~

~~(3)~~ (1) meet with ~~mental health rehabilitation workers and practitioners, individually or in small groups,~~ staff receiving direction at least monthly to discuss treatment topics of interest ~~to the workers and practitioners~~;

~~(4) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to~~ (2) discuss treatment plans of recipients~~, and approve by signature and document in the recipient's file any resulting plan updates~~;

~~(5) meet at least monthly with the directing mental health practitioner, if there is one, to~~ (3) review needs of the adult rehabilitative mental health services program, review staff on-site observations and evaluate mental health rehabilitation workers, plan staff training, and review program evaluation and development~~, and consult with the directing practitioner; and~~;

~~(6) be available for urgent consultation as the individual recipient needs or the situation necessitates.~~

~~(d) An adult rehabilitative mental health services provider entity must have a treatment director who is a mental health practitioner or mental health professional. The treatment director must ensure the following:~~

~~(1) while delivering direct services to recipients, a newly hired mental health rehabilitation worker must be directly observed delivering services to recipients by a mental health practitioner or mental health professional for at least six hours per 40 hours worked during the first 160 hours that the mental health rehabilitation worker works;~~

~~(2) the mental health rehabilitation worker must receive ongoing on-site direct service observation by a mental health professional or mental health practitioner for at least six hours for every six months of employment;~~

~~(3)~~ (4) review progress notes ~~are reviewed~~ from on-site service observation prepared by the mental health rehabilitation worker and mental health practitioner for accuracy and consistency with actual recipient contact and the individual treatment plan and goals;

~~(4)~~ (5) ensure immediate availability by phone or in person for consultation by a mental health professional or a mental health practitioner to the mental health rehabilitation services worker during service provision; and

~~(5) oversee the identification of changes in individual recipient treatment strategies, revise the plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;~~

~~(6) model service practices which: respect the recipient, include the recipient in planning and implementation of the individual treatment plan, recognize the recipient's strengths, collaborate and coordinate with other involved parties and providers;~~

~~(7)~~ (6) ensure that mental health practitioners and mental health rehabilitation workers are able to effectively communicate with the recipients, significant others, and providers~~;~~ ~~and~~.

~~(8) oversee the record of the results of on-site observation and charting evaluation and corrective actions taken to modify the work of the mental health practitioners and mental health rehabilitation workers.~~

~~(c) A mental health practitioner who is providing treatment direction for a provider entity must receive supervision at least monthly from a mental health professional to:~~

~~(1) identify and plan for general needs of the recipient population served;~~

~~(2) identify and plan to address provider entity program needs and effectiveness;~~

~~(3) identify and plan provider entity staff training and personnel needs and issues; and~~

~~(4) plan, implement, and evaluate provider entity quality improvement programs.~~

Sec. 67. Minnesota Statutes 2018, section 256B.0623, subdivision 7, is amended to read:

Subd. 7. **Personnel file.** The adult rehabilitative mental health services provider entity must maintain a personnel file on each staff in accordance with section 245I.13. ~~Each file must contain:~~

~~(1) an annual performance review;~~

~~(2) a summary of on-site service observations and charting review;~~

~~(3) a criminal background check of all direct service staff;~~

~~(4) evidence of academic degree and qualifications;~~

~~(5) a copy of professional license;~~

~~(6) any job performance recognition and disciplinary actions;~~

~~(7) any individual staff written input into own personnel file;~~

~~(8) all clinical supervision provided; and~~

~~(9) documentation of compliance with continuing education requirements.~~

Sec. 68. Minnesota Statutes 2018, section 256B.0623, subdivision 8, is amended to read:

Subd. 8. **Diagnostic assessment.** Providers of adult rehabilitative mental health services must obtain or complete a diagnostic assessment ~~as defined in~~ according to section ~~245.462, subdivision 9, within five days after the recipient's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available that reflects the recipient's current status, and has been completed within three years preceding admission, an adult diagnostic assessment update must be completed. An update shall include a face-to-face interview with the recipient and a written summary by a mental health professional of the recipient's current mental health status and service needs. If the recipient's mental health status has changed significantly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required~~ 256B.0671, subdivisions 2 and 3.

Sec. 69. Minnesota Statutes 2018, section 256B.0623, subdivision 10, is amended to read:

Subd. 10. **Individual treatment plan.** All providers of adult rehabilitative mental health services must develop and implement an individual treatment plan for each recipient. ~~The provisions in clauses (1) and (2) apply:~~ according to section 256B.0671, subdivisions 5 and 6.

~~(1) Individual treatment plan means a plan of intervention, treatment, and services for an individual recipient written by a mental health professional or by a mental health practitioner under the clinical supervision of a mental health professional. The individual treatment plan must be based on diagnostic and functional assessments. To the extent possible, the development and implementation of a treatment plan must be a collaborative process involving the recipient, and with the permission of the recipient, the recipient's family and others in the recipient's support system. Providers of adult rehabilitative mental health services must develop the individual treatment plan within 30 calendar days of intake.~~ The treatment plan must be updated at least every six months thereafter, or more often when there is significant change in the recipient's situation or functioning, or in services or service methods to be used, or at the request of the recipient or the recipient's legal guardian.

~~(2) The individual treatment plan must include:~~

~~(i) a list of problems identified in the assessment;~~

~~(ii) the recipient's strengths and resources;~~

~~(iii) concrete, measurable goals to be achieved, including time frames for achievement;~~

~~(iv) specific objectives directed toward the achievement of each one of the goals;~~

~~(v) documentation of participants in the treatment planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the treatment plan, or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient or legal guardian. Referral to formal services must be arranged, including specific providers where applicable;~~

~~(vi) cultural considerations, resources, and needs of the recipient must be included;~~

~~(vii) planned frequency and type of services must be initiated; and~~

~~(viii) clear progress notes on outcome of goals.~~

~~(3) The individual community support plan defined in section 245.462, subdivision 12, may serve as the individual treatment plan if there is involvement of a mental health case manager, and with the approval of the recipient. The individual community support plan must include the criteria in clause (2).~~

Sec. 70. Minnesota Statutes 2018, section 256B.0623, subdivision 11, is amended to read:

Subd. 11. **Recipient file.** Providers of adult rehabilitative mental health services must maintain a file for each recipient ~~that contains the following information:~~ according to section 245I.32.

~~(1) diagnostic assessment or verification of its location that is current and that was reviewed by a mental health professional who is employed by or under contract with the provider entity;~~

~~(2) functional assessments;~~

~~(3) individual treatment plans signed by the recipient and the mental health professional, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;~~

~~(4) recipient history;~~

~~(5) signed release forms;~~

~~(6) recipient health information and current medications;~~

~~(7) emergency contacts for the recipient;~~

~~(8) case records which document the date of service, the place of service delivery, signature of the person providing the service, nature, extent and units of service, and place of service delivery;~~

~~(9) contacts, direct or by telephone, with recipient's family or others, other providers, or other resources for service coordination;~~

~~(10) summary of recipient case reviews by staff; and~~

~~(11) written information by the recipient that the recipient requests be included in the file.~~

Sec. 71. Minnesota Statutes 2018, section 256B.0623, subdivision 12, is amended to read:

Subd. 12. **Additional requirements.** (a) Providers of adult rehabilitative mental health services must comply with the requirements relating to referrals for case management in section 245.467, subdivision 4.

(b) Adult rehabilitative mental health services are provided for most recipients in the recipient's home and community. Services may also be provided at the home of a relative or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom, or other places in the community. Except for "transition to community services," the place of service does not include a regional treatment center, nursing home, residential treatment facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36), or an acute care hospital.

(c) Adult rehabilitative mental health services may be provided in group settings if appropriate to each participating recipient's needs and treatment plan. A group is defined as two to ten clients, at least one of whom is a recipient, who is concurrently receiving a service which is identified in this section. The service and group must be specified in the recipient's treatment plan. No more than two qualified staff may bill Medicaid for services provided to the same group of recipients. If two adult rehabilitative mental health workers bill for recipients in the same group session, they must each bill for different recipients.

(d) Adult rehabilitative mental health services are appropriate if provided to enable a recipient to retain stability and functioning, when the recipient is at risk of significant functional decompensation or requiring more restrictive service settings without these services.

(e) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas including: interpersonal communication skills, community resource utilization and integration skills, crisis planning, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, parenting skills, and transition to community living services.

(f) Community intervention, including consultation with relatives, guardians, friends, employers, treatment providers, and other significant individuals, is appropriate when directed exclusively to the treatment of the client.

Sec. 72. Minnesota Statutes 2018, section 256B.0624, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Mental health crisis" is an adult behavioral, emotional, or psychiatric situation which, but for the provision of crisis response services, would likely result in significantly reduced levels of functioning in primary activities of daily living, or in an emergency situation, or in the placement of the recipient in a more restrictive setting, including, but not limited to, inpatient hospitalization.

(b) "Mental health emergency" is an adult behavioral, emotional, or psychiatric situation which causes an immediate need for mental health services and is consistent with section 62Q.55.

A mental health crisis or emergency is determined for medical assistance service reimbursement by a physician, a mental health professional, or ~~crisis mental health practitioner~~ qualified member of a crisis team with input from the recipient whenever possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, a mental health professional, or ~~mental health practitioner under the clinical supervision of a mental health professional,~~ qualified member of a crisis team following a screening that suggests that the adult may be experiencing a mental health crisis or mental health emergency situation. It includes, when feasible, assessing whether the person might be willing to voluntarily accept treatment, determining whether the person has an advance directive, and obtaining information and history from involved family members or caretakers.

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, engage in voluntary treatment, and begin to return to the recipient's baseline level of functioning. The services, including screening and treatment plan recommendations, must be culturally and linguistically appropriate.

(1) This service is provided on site by a mobile crisis intervention team outside of an inpatient hospital setting. Mental health mobile crisis intervention services must be available 24 hours a day, seven days a week.

(2) The initial screening must consider other available services to determine which service intervention would best address the recipient's needs and circumstances.

(3) The mobile crisis intervention team must be available to meet promptly face-to-face with a person in mental health crisis or emergency in a community setting or hospital emergency room.

(4) The intervention must consist of a mental health crisis assessment and a crisis treatment plan.

(5) The team must be available to individuals who are experiencing a co-occurring substance use disorder, who do not need the level of care provided in a detoxification facility.

(6) The treatment plan must include recommendations for any needed crisis stabilization services for the recipient, including engagement in treatment planning and family psychoeducation.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services which are designed to restore the recipient to the recipient's prior functional level. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, another community setting, or a short-term supervised, licensed residential program. Mental health crisis stabilization does not include partial hospitalization or day treatment. Mental health crisis stabilization services includes family psychoeducation.

(f) "Clinical trainee" means a person qualified according to section 245I.16, subdivision 6.

(g) "Mental health certified family peer specialist" means a person qualified according to section 245I.16, subdivision 12.

(h) "Mental health certified peer specialist" means a person qualified according to section 245I.16, subdivision 10.

(i) "Mental health practitioner" means a person qualified according to section 245I.16, subdivision 4.

(j) "Mental health professional" means a person qualified according to section 245I.16, subdivision 2.

(k) "Mental health rehabilitation worker" means a person qualified according to section 245I.16, subdivision 14.

Sec. 73. Minnesota Statutes 2018, section 256B.0624, subdivision 4, is amended to read:

Subd. 4. **Provider entity standards.** (a) A provider entity is an entity that meets the standards listed in paragraph (c) and:

(1) is a county board operated entity; ~~or~~

(2) is an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under United States Code, title 25, section 450f; or

(3) is a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring. To provide services under this section, the provider entity must directly provide the services; or if services are subcontracted, the provider entity must maintain responsibility for services and billing.

(b) A provider entity that provides crisis stabilization services in a residential setting under subdivision 7 is not required to meet the requirements of paragraph (a), clauses (1) ~~and (2)~~ to (3), and paragraph (c), clauses (9), (20), and (21), but must meet all other

requirements of this subdivision. Upon approval by the commissioner, a residential crisis services provider meeting relevant standards for supervision and assessment may allow a practitioner to perform a crisis assessment to establish eligibility for admission to the program. A provider performing an assessment under this paragraph shall not bill separately beyond the daily rate for the residential stabilization program.

(c) The adult mental health crisis response services provider entity must have the capacity to meet and carry out the requirements in chapter 245I and the following standards:

(1) has the capacity to recruit, hire, and manage and train ~~mental health professionals, practitioners, and rehabilitation workers~~ qualified staff;

(2) has adequate administrative ability to ensure availability of services;

(3) is able to ensure adequate preservice and in-service training;

(4) is able to ensure that staff providing these services are skilled in the delivery of mental health crisis response services to recipients;

(5) is able to ensure that staff are capable of implementing culturally specific treatment identified in the individual treatment plan that is meaningful and appropriate as determined by the recipient's culture, beliefs, values, and language;

(6) is able to ensure enough flexibility to respond to the changing intervention and care needs of a recipient as identified by the recipient during the service partnership between the recipient and providers;

(7) is able to ensure that ~~mental health professionals and mental health practitioners~~ staff have the communication tools and procedures to communicate and consult promptly about crisis assessment and interventions as services occur;

(8) is able to coordinate these services with county emergency services, community hospitals, ambulance, transportation services, social services, law enforcement, and mental health crisis services through regularly scheduled interagency meetings;

(9) is able to ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;

(10) is able to ensure that services are coordinated with other mental health service providers, county mental health authorities, or federally recognized American Indian authorities and others as necessary, with the consent of the ~~adult~~ recipient. Services must also be coordinated with the recipient's case manager if the adult is receiving case management services;

(11) is able to coordinate services with detoxification according to Minnesota Rules, parts 9530.6605 to 9530.6655, or withdrawal management according to chapter 245F to ensure a recipient receives care that is responsive to the recipient's chemical and mental health needs;

(12) is able to ensure that crisis intervention services are provided in a manner consistent with sections 245.461 to 245.486;

~~(12)~~ (13) is able to submit information as required by the state;

~~(13)~~ (14) maintains staff training and personnel files, including documentation of staff completion of required training modules;

~~(14)~~ (15) is able to establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction, including notifying recipients of the process by which the provider, county, or tribe accepts and responds to concerns;

~~(15)~~ (16) is able to keep records as required by applicable laws;

~~(16)~~ (17) is able to comply with all applicable laws and statutes;

~~(17)~~ (18) is an enrolled medical assistance provider; ~~and~~

~~(18)~~ (19) develops and maintains written policies and procedures regarding service provision and administration of the provider entity, including safety of staff and recipients in high-risk situations~~.~~;

(20) is able to respond to a call for crisis services in a designated service area or according to a written agreement with the local mental health authority for an adjacent area; and

(21) documents protocol used when delivering services by telemedicine, according to sections 62A.67 to 62A.672, including responsibilities of the originating site, means to promote recipient safety, timeliness for connection and response, and steps to take in the event of a lost connection.

Sec. 74. Minnesota Statutes 2018, section 256B.0624, subdivision 5, is amended to read:

Subd. 5. **Mobile crisis intervention staff qualifications.** ~~For provision of adult mental health mobile crisis intervention services, a mobile crisis intervention team is comprised of at least two mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (6), or a combination of at least one mental health professional and one mental health practitioner as defined in section 245.462, subdivision 17, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team.~~

(a) Mobile crisis intervention team staff must be qualified to provide services as mental health professionals, mental health practitioners, clinical trainees, mental health certified family peer specialists, or mental health certified peer specialists.

(b) A mobile crisis intervention team is comprised of at least two members, one of whom must be qualified as a mental health professional. A second member must be qualified as a mental health professional, clinical trainee, or mental health practitioner. A provider entity must consider the needs of the area served when adding staff.

(c) Mental health crisis assessment and intervention services must be led by a mental health professional, or under the supervision of a mental health professional according to subdivision 9, by a clinical trainee or mental health practitioner.

(d) The team must have ~~at least two people with~~ at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, treatment engagement strategies, working with families, and clinical decision-making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources such as the county social services agency, mental health services, and local law enforcement when necessary.

Sec. 75. Minnesota Statutes 2018, section 256B.0624, subdivision 6, is amended to read:

Subd. 6. **Crisis assessment and mobile intervention treatment planning.** (a) Prior to initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.462, subdivision 6, and 245.469, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify parties involved, and determine an appropriate response. Nothing in this section precludes crisis staff from answering a call from a third party.

(b) In conducting the screening, a provider shall:

(1) employ evidence-based practices as identified by the commissioner in collaboration with the commissioner of health to reduce the risk of the recipient's suicide and self-injurious behavior;

(2) work with the recipient to establish a plan and time frame for responding to the crisis, including immediate needs for support by telephone or text message until a face-to-face response arrives;

(3) document significant factors related to the determination of a crisis, including prior calls to the crisis team, recent presentation at an emergency department, known calls to 911 or law enforcement, or third parties with knowledge of a potential recipient's history or current needs;

(4) screen for the needs of a third-party caller, including a recipient who primarily identifies as a family member or a caregiver but also presents signs of a crisis; and

(5) provide psychoeducation, including education on the available means for reducing self-harm, to relevant third parties, including family members or other persons living in the home.

(c) A provider entity shall consider the following to indicate a positive screening unless the provider entity documents specific evidence to show why crisis response was clinically inappropriate:

(1) the recipient presented in an emergency department or urgent care setting, and the health care team at that location requested crisis services; or

(2) a peace officer requested crisis services for a recipient who may be subject to transportation under section 253B.05 for a mental health crisis.

~~(b)~~ (d) If a crisis exists, a crisis assessment must be completed. A crisis assessment evaluates any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, health information including current medications, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, current functioning, and the recipient's preferences as communicated directly by the recipient, or as communicated in a health care directive as described in chapters 145C and 253B, the treatment plan described under paragraph (d), a crisis prevention plan, or a wellness recovery action plan.

~~(c)~~ (e) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As opportunity presents during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek ~~clinical~~ treatment supervision as required in subdivision 9.

(f) Direct contact with the recipient is not required before initiating a crisis assessment or intervention service. A crisis team may gather relevant information from a third party at

the scene to establish the need for services and potential safety factors. A crisis assessment is provided face-to-face by a mobile crisis intervention team outside of an inpatient hospital setting. A service must be provided promptly and respond to the recipient's location whenever possible, including community or clinical settings. As clinically appropriate, a mobile crisis intervention team must coordinate a response with other health care providers if a recipient requires detoxification, withdrawal management, or medical stabilization services in addition to crisis services.

~~(d)~~ (g) The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The treatment plan must be updated as needed to reflect current goals and services.

~~(e)~~ (h) The team must document which short-term goals have been met and when no further crisis intervention services are required. If after an assessment a crisis provider entity refers a recipient to an intensive setting, including an emergency department, in-patient hospitalization, or crisis residential treatment, one of the crisis team members who performed or conferred on the assessment must immediately contact the provider entity and consult with the triage nurse or other staff responsible for intake. The crisis team member must convey key findings or concerns that led to the referral. The consultation shall occur with the recipient's consent, the recipient's legal guardian's consent, or as allowed by section 144.293, subdivision 5. Any available written documentation, including a crisis treatment plan, must be sent no later than the next business day.

~~(f)~~ (i) If the recipient's crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager. If the recipient is unable to follow up on the referral, the team must link the recipient to the service and follow up to ensure the recipient is receiving the service.

~~(g)~~ (j) If the recipient's crisis is stabilized and the recipient does not have an advance directive, the case manager or crisis team shall offer to work with the recipient to develop one.

(k) If an intervention service is provided without the recipient present, the provider shall document the reasons why the service is more effective without the recipient present.

Sec. 76. Minnesota Statutes 2018, section 256B.0624, subdivision 7, is amended to read:

Subd. 7. **Crisis stabilization services.** (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8; ~~and~~

(3) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community~~.~~; and

(4) if a stabilization service is provided without the recipient present, the provider shall document the reasons why the service is more effective without the recipient present.

(b) If crisis stabilization services are provided in a supervised, licensed residential setting, the recipient must be contacted face-to-face daily by a qualified mental health practitioner or mental health professional. The program must have 24-hour-a-day residential staffing which may include staff who do not meet the qualifications in subdivision 8. The residential staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental health professional or practitioner.

(c) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and one or more individuals are present at the setting to receive residential crisis stabilization services, the residential staff must include, for at least eight hours per day, at least one individual who meets the qualifications in subdivision 8, paragraph (a), clause (1) or (2).

(d) If crisis stabilization services are provided in a supervised, licensed residential setting that serves more than four adult residents, and one or more are recipients of crisis stabilization services, the residential staff must include, for 24 hours a day, at least one individual who meets the qualifications in subdivision 8. When more than four residents are present at the setting during the first 48 hours that a recipient is in the residential program, the residential program must have at least two staff working 24 hours a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as specified in the crisis stabilization treatment plan.

Sec. 77. Minnesota Statutes 2018, section 256B.0624, subdivision 8, is amended to read:

Subd. 8. **Adult crisis stabilization staff qualifications.** ~~(a)~~ Adult mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. Individual provider staff must ~~have the following qualifications~~ be:

(1) ~~be~~ a mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6)~~;

(2) ~~be~~ a mental health practitioner ~~as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional~~;

(3) ~~be~~ a mental health certified peer specialist ~~under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional~~; or

(4) ~~be~~ a mental health rehabilitation worker ~~who meets the criteria in section 256B.0623, subdivision 5, paragraph (a), clause (4); works under the direction of a mental health practitioner as defined in section 245.462, subdivision 17, or under direction of a mental health professional; and works under the clinical supervision of a mental health professional~~.

~~(b) Mental health practitioners and mental health rehabilitation workers must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.~~

Sec. 78. Minnesota Statutes 2018, section 256B.0624, subdivision 9, is amended to read:

Subd. 9. **Supervision.** Mental health practitioners or clinical trainees may provide crisis assessment and mobile crisis intervention services if the following ~~clinical~~ treatment supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by phone or in person for clinical supervision;

(3) the mental health professional is consulted, in person or by phone, during the first three hours when a mental health practitioner or clinical trainee provides on-site service;

(4) the mental health professional must:

(i) review and approve of the tentative crisis assessment and crisis treatment plan;

(ii) document the consultation; and

(iii) sign the crisis assessment and treatment plan within the next business day; and

~~(5) if the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the recipient face-to-face on the second day to provide services and update the crisis treatment plan; and~~

~~(6)~~ (5) the on-site observation must be documented in the recipient's record and signed by the mental health professional.

Sec. 79. Minnesota Statutes 2018, section 256B.0624, subdivision 11, is amended to read:

Subd. 11. **Treatment plan.** The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement;

(4) specific objectives directed toward the achievement of each one of the goals;

(5) documentation of the participants involved in the service planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient and the recipient's legal guardian. The plan should include services arranged, including specific providers where applicable;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur;

(8) clear progress notes on outcome of goals;

(9) a written plan must be completed within 24 hours of beginning services with the recipient; and

(10) a treatment plan must be developed by a mental health professional, clinical trainee, or mental health practitioner ~~under the clinical supervision of a mental health professional~~. The mental health professional must approve and sign all treatment plans.

Sec. 80. Minnesota Statutes 2018, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine in the same manner as if the service or consultation was delivered in person. Coverage is limited to three telemedicine services per enrollee per calendar week. Telemedicine services shall be paid at the full allowable rate.

(b) The commissioner shall establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service via telemedicine. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide via telemedicine;

(2) has written policies and procedures specific to telemedicine services that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the telemedicine service is rendered;

(4) has established protocols addressing how and when to discontinue telemedicine services; and

(5) has an established quality assurance process related to telemedicine services.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service provided by telemedicine to a medical assistance enrollee. Health care service records for services provided by telemedicine must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service provided by telemedicine;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) the licensed health care provider's basis for determining that telemedicine is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission of the telemedicine service and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's telemedicine consultation with another physician, the written opinion from the consulting physician providing the telemedicine consultation; and

(7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) For purposes of this subdivision, unless otherwise covered under this chapter, "telemedicine" is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

(e) For purposes of this section, "licensed health care provider" means a licensed health care provider under section 62A.671, subdivision 6, a clinical trainee, and a mental health practitioner defined under section 245.462, subdivision 17~~, or 245.4871, subdivision 26~~, working under the general supervision of a mental health professional; "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

Sec. 81. Minnesota Statutes 2018, section 256B.0625, subdivision 5, is amended to read:

Subd. 5. **Community mental health center services.** Medical assistance covers community mental health center services provided by a community mental health center that meets the requirements in paragraphs (a) to (j).

(a) The provider is licensed under Minnesota Rules, parts 9520.0750 to 9520.0870, and in compliance with requirements under chapter 245I and section 256B.0671.

(b) The provider provides mental health services under the ~~clinical~~ treatment supervision of a mental health professional who is licensed for independent practice at the doctoral level or by a board-certified psychiatrist or a psychiatrist who is eligible for board certification. ~~Clinical supervision has the meaning given in Minnesota Rules, part 9505.0370, subpart 6.~~ Treatment supervision means the treatment supervision described under section 245I.18.

(c) The provider must be a private nonprofit corporation or a governmental agency and have a community board of directors as specified by section 245.66.

(d) The provider must have a sliding fee scale that meets the requirements in section 245.481, and agree to serve within the limits of its capacity all individuals residing in its service delivery area.

(e) At a minimum, the provider must provide the following outpatient mental health services: diagnostic assessment; explanation of findings; and family, group, and individual psychotherapy, including crisis intervention psychotherapy services~~, multiple family group psychotherapy~~, psychological testing, and medication management. In addition, the provider must provide or be capable of providing upon request of the local mental health authority day treatment services, multiple family group psychotherapy, and professional home-based mental health services. The provider must have the capacity to provide such services to specialized populations such as the elderly, families with children, persons who are seriously and persistently mentally ill, and children who are seriously emotionally disturbed.

(f) The provider must be capable of providing the services specified in paragraph (e) to individuals who are dually diagnosed with ~~both~~ a mental illness or emotional disturbance~~,~~ and ~~chemical dependency~~ substance use disorder, and to individuals who are dually diagnosed with a mental illness or emotional disturbance and developmental disability.

(g) The provider must provide 24-hour emergency care services or demonstrate the capacity to assist recipients in need of such services to access such services on a 24-hour basis.

(h) The provider must have a contract with the local mental health authority to provide one or more of the services specified in paragraph (e).

(i) The provider must agree, upon request of the local mental health authority, to enter into a contract with the county to provide mental health services not reimbursable under the medical assistance program.

(j) The provider may not be enrolled with the medical assistance program as both a hospital and a community mental health center. The community mental health center's administrative, organizational, and financial structure must be separate and distinct from that of the hospital.

Sec. 82. Minnesota Statutes 2018, section 256B.0625, subdivision 5l, is amended to read:

Subd. 5l. **Intensive mental health outpatient treatment.** (a) Medical assistance covers intensive mental health outpatient treatment for dialectical behavioral therapy for adults. The commissioner shall establish:

(1) certification procedures to ensure that providers of these services are qualified and meet the standards in chapter 245I; and

(2) treatment protocols including required service components and criteria for admission, continued treatment, and discharge.

(b) "Dialectical behavior therapy" means an evidence-based treatment approach provided in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program involves the following service components: individual dialectical behavior therapy, group skills training, telephone coaching, and team consultation meetings.

(c) To be eligible for dialectical behavior therapy a client must:

(1) be 18 years of age or older;

(2) have mental health needs that cannot be met with other available community-based services or that must be provided concurrently with other community-based services;

(3) meet one of the following criteria:

(i) have a diagnosis of borderline personality disorder; or

(ii) have multiple mental health diagnoses, exhibit behaviors characterized by impulsivity or intentional self-harm, and be at significant risk of death, morbidity, disability, or severe dysfunction across multiple life areas;

(4) understand and be cognitively capable of participating in dialectical behavior therapy as an intensive therapy program and be able and willing to follow program policies and rules ensuring safety of self and others; and

(5) be at significant risk of one or more of the following if dialectical behavior therapy is not provided:

(i) having a mental health crisis;

(ii) requiring a more restrictive setting including hospitalization;

(iii) decompensation; or

(iv) engaging in intentional self-harm behavior.

(d) Individual dialectical behavior therapy combines individualized rehabilitative and psychotherapeutic interventions to treat suicidal and other dysfunctional behaviors and reinforce the use of adaptive skillful behaviors. Individual dialectical behavior therapy must be provided by a mental health professional or a clinical trainee. The mental health professional or clinical trainee must:

(1) identify, prioritize, and sequence behavioral targets;

(2) treat behavioral targets;

(3) generalize dialectical behavior therapy skills to the client's natural environment through telephone coaching outside of the treatment session;

(4) measure the client's progress toward dialectical behavior therapy targets;

(5) help the client manage mental health crises and life-threatening behaviors; and

(6) help the client learn and apply effective behaviors when working with other treatment providers.

(e) Group skills training combines individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group setting to reduce the client's suicidal and other dysfunctional coping behaviors and restore function. Group skills training must teach the client adaptive skills in the following areas:

(1) mindfulness;

(2) interpersonal effectiveness;

(3) emotional regulation; and

(4) distress tolerance.

(f) Group skills training must be provided by two mental health professionals, or by a mental health professional co-facilitating with a clinical trainee or a mental health practitioner as specified in section 245I.16, subdivision 4. Individual skills training must be provided by a mental health professional, a clinical trainee, or a mental health practitioner as specified in section 245I.16, subdivision 4.

(g) A program must be certified by the commissioner as a dialectical behavior therapy provider. To qualify for certification, a provider must:

(1) submit to the commissioner's inspection;

(2) provide evidence that the dialectical behavior therapy program's policies, procedures, and practices continuously meet the requirements of this subdivision;

(3) be enrolled as a MHCP provider;

(4) collect and report client outcomes as specified by the commissioner; and

(5) have a manual that outlines the dialectical behavior therapy program's policies, procedures, and practices that meet the requirements of this subdivision.

Sec. 83. Minnesota Statutes 2018, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services provided by an individual who is qualified to provide the services according to subdivision 19a and sections 256B.0651 to 256B.0654, provided in accordance with a plan, and supervised by a qualified professional.

"Qualified professional" means a mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6)~~; a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker as defined in sections 148E.010 and 148E.055, or a qualified designated coordinator under section 245D.081, subdivision 2. The qualified professional shall perform the duties required in section 256B.0659.

Sec. 84. Minnesota Statutes 2018, section 256B.0625, subdivision 23, is amended to read:

Subd. 23. **Adult day treatment services.** (a) Medical assistance covers adult day treatment services as specified in sections 245.462, subdivision 8, and 245.4871, subdivision 10, that are provided under contract with the county board. The commissioner may set authorization thresholds for day treatment for adults according to subdivision 25. Medical assistance covers day treatment services for children as specified under section 256B.0943. Adult day treatment payment is limited to the conditions in paragraphs (b) to (e).

(b) Adult day treatment is an intensive psychotherapeutic treatment to reduce or relieve the effects of mental illness to enable the client to benefit from a lower level of care and to live and function more independently in the community. Adult day treatment services must stabilize the client's mental health status and develop and improve the client's independent living and socialization skills. Adult day treatment must consist of at least one hour of group psychotherapy and must include group time focused on rehabilitative interventions or other therapeutic services that are provided by a multidisciplinary staff person. Adult day treatment services are not a part of inpatient or residential treatment services.

(c) To be eligible for medical assistance payment, an adult day treatment service must:

(1) be reviewed by and approved by the commissioner;

(2) be provided to a group of clients by a multidisciplinary staff person under the treatment supervision of a mental health professional as described under section 245I.18;

(3) be available to the client at least two days a week for at least three consecutive hours per day. The adult day treatment may be longer than three hours per day, but medical assistance must not reimburse a provider for more than 15 hours per week;

(4) include group psychotherapy by a mental health professional or clinical trainee and daily rehabilitative interventions by a mental health professional qualified according to section 245I.16, subdivision 2, clinical trainee qualified according to section 245I.16, subdivision 6, or mental health practitioner qualified according to section 245I.16, subdivision 4;

(5) be included in the client's individual treatment plan as described under section 256B.0671, subdivisions 5 and 6, as appropriate. The individual treatment plan must include attainable, measurable goals related to services and must be completed before the first adult day treatment session. The vendor must review the client's progress and update the treatment plan at least every 30 days until the client is discharged and include an available discharge plan for the client in the treatment plan; and

(6) document the daily interventions provided and the client's response according to section 245I.33.

(d) To be eligible for adult day treatment, a client must:

(1) be 18 years of age or older;

(2) not be residing in a nursing facility, hospital, institute of mental disease, or regional treatment center unless the client has an active discharge plan that indicates a move to an independent living arrangement within 180 days;

(3) have a diagnosis of mental illness as determined by a diagnostic assessment;

(4) have the capacity to engage in the rehabilitative nature, the structured setting, and the therapeutic parts of psychotherapy and skills activities of an adult day treatment program and demonstrate measurable improvements in the client's functioning related to the client's mental illness that would result from participating in the adult day treatment program;

(5) have at least three areas of functional impairment as determined by a functional assessment with the domains prescribed by section 245.462, subdivision 11a;

(6) have a level of care determination that supports the need for the level of intensity and duration of an adult day treatment program; and

(7) be determined to need adult day treatment services by a mental health professional who must deem the adult day treatment services medically necessary.

(e) The following services are not covered by medical assistance as an adult day treatment service:

(1) a service that is primarily recreation-oriented or that is provided in a setting that is not medically supervised. This includes sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(2) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's mental illness;

(3) consultation with other providers or service agency staff persons about the care or progress of a client;

(4) prevention or education programs provided to the community;

(5) day treatment for clients with primary diagnoses of alcohol or other drug abuse;

(6) day treatment provided in the client's home;

(7) psychotherapy for more than two hours per day; and

(8) participation in meal preparation and eating that is not part of a clinical treatment plan to address the client's eating disorder.

Sec. 85. Minnesota Statutes 2018, section 256B.0625, subdivision 42, is amended to read:

Subd. 42. **Mental health professional.** Notwithstanding Minnesota Rules, part 9505.0175, subpart 28, the definition of a mental health professional shall include a person who is qualified as specified in section ~~245.462, subdivision 18, clauses (1) to (6); or 245.4871, subdivision 27, clauses (1) to (6),~~ 245I.16, subdivision 2, for the purpose of this section and Minnesota Rules, parts 9505.0170 to 9505.0475.

Sec. 86. Minnesota Statutes 2018, section 256B.0625, subdivision 48, is amended to read:

Subd. 48. **Psychiatric consultation to primary care practitioners.** Medical assistance covers consultation provided by a ~~psychiatrist, a psychologist, an advanced practice registered nurse certified in psychiatric mental health, a licensed independent clinical social worker, as defined in section 245.462, subdivision 18, clause (2), or a licensed marriage and family~~

~~therapist, as defined in section 245.462, subdivision 18, clause (5),~~ mental health professional except one licensed under section 148B.5301 via telephone, e-mail, facsimile, or other means of communication to primary care practitioners, including pediatricians. The need for consultation and the receipt of the consultation must be documented in the patient record maintained by the primary care practitioner. If the patient consents, and subject to federal limitations and data privacy provisions, the consultation may be provided without the patient present.

Sec. 87. Minnesota Statutes 2018, section 256B.0625, subdivision 49, is amended to read:

Subd. 49. **Community health worker.** (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has~~: (1)~~ received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum~~; or~~.

~~(2) at least five years of supervised experience with an enrolled physician, registered nurse, advanced practice registered nurse, mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or at least five years of supervised experience by a certified public health nurse operating under the direct authority of an enrolled unit of government.~~

~~Community health workers eligible for payment under clause (2) must complete the certification program by January 1, 2010, to continue to be eligible for payment.~~

(b) Community health workers must work under the supervision of a medical assistance enrolled physician, registered nurse, advanced practice registered nurse, mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5)~~, or dentist, or work under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government.

(c) Care coordination and patient education services covered under this subdivision include, but are not limited to, services relating to oral health and dental care.

Sec. 88. Minnesota Statutes 2018, section 256B.0625, subdivision 56a, is amended to read:

Subd. 56a. **~~Post-arrest~~ Officer-involved community-based ~~service~~ care coordination.** (a) Medical assistance covers ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination for an individual who:

(1) has ~~been identified as having~~ screened positive for benefiting from treatment for a mental illness or substance use disorder using a ~~screening~~ tool approved by the commissioner;

(2) does not require the security of a public detention facility and is not considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010;

(3) meets the eligibility requirements in section 256B.056; and

(4) has agreed to participate in ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination ~~through a diversion contract in lieu of incarceration~~.

(b) ~~Post-arrest~~ Officer-involved community-based ~~service~~ care coordination means navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of jail utilization and connecting individuals with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination.

(c) ~~Post-arrest~~ Officer-involved community-based ~~service~~ care coordination must be provided by an individual who is an employee of ~~a county~~ or is under contract with a county, or is an employee of or under contract with an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law 93-638 as a 638 facility to provide ~~post-arrest~~ officer-involved community-based care coordination and is qualified under one of the following criteria:

(1) a licensed mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6)~~;

(2) a mental health practitioner as defined in section 245.462, subdivision 17, working under the ~~clinical~~ treatment supervision of a mental health professional; ~~or~~

(3) a certified peer specialist under section 256B.0615, working under the ~~clinical~~ treatment supervision of a mental health professional~~.~~;

(4) a clinical trainee;

(5) an individual qualified as an alcohol and drug counselor under section 245G.11, subdivision 5; or

(6) a recovery peer qualified under section 245G.11, subdivision 8, working under the supervision of an individual qualified as an alcohol and drug counselor under section 245G.11, subdivision 5.

(d) Reimbursement is allowed for up to 60 days following the initial determination of eligibility.

(e) Providers of ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination shall annually report to the commissioner on the number of individuals served, and number of the community-based services that were accessed by recipients. The commissioner shall ensure that services and payments provided under ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination do not duplicate services or payments provided under section 256B.0625, subdivision 20, 256B.0753, 256B.0755, or 256B.0757.

(f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for post-arrest community-based service coordination services shall be provided by the county providing the services, from sources other than federal funds or funds used to match other federal funds.

Sec. 89. Minnesota Statutes 2018, section 256B.0625, subdivision 61, is amended to read:

Subd. 61. **Family psychoeducation services.** ~~Effective July 1, 2013, or upon federal approval, whichever is later,~~ Medical assistance covers family psychoeducation services provided to a child up to age 21 with a diagnosed mental health condition when identified in the child's individual treatment plan and provided by a licensed mental health professional~~,~~ ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item A,~~ or a clinical trainee~~, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C,~~ who has determined it medically necessary to involve family members in the child's care. For the purposes of this subdivision, "family psychoeducation services" means information or demonstration provided to an individual or family as part of an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

Sec. 90. Minnesota Statutes 2018, section 256B.0625, subdivision 62, is amended to read:

Subd. 62. **Mental health clinical care consultation.** ~~Effective July 1, 2013, or upon federal approval, whichever is later,~~ Medical assistance covers clinical care consultation for a person up to age 21 who is diagnosed with a complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions, when described in the person's individual treatment plan and provided by a licensed mental health

professional~~, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A,~~ or a clinical trainee~~, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C~~. For the purposes of this subdivision, "clinical care consultation" means communication from a treating mental health professional to other providers or educators not under the clinical supervision of the treating mental health professional who are working with the same client to inform, inquire, and instruct regarding the client's symptoms; strategies for effective engagement, care, and intervention needs; and treatment expectations across service settings; and to direct and coordinate clinical service components provided to the client and family.

Sec. 91. Minnesota Statutes 2018, section 256B.0625, subdivision 65, is amended to read:

Subd. 65. **Outpatient mental health services.** For the purposes of this section, "clinical trainee" has the meaning given in section 245I.16, subdivision 6. Medical assistance covers diagnostic assessment, explanation of findings, and psychotherapy according to ~~Minnesota Rules, part 9505.0372,~~ subdivision 69 and section 256B.0671 when the mental health services are performed by ~~a mental health practitioner working as~~ a clinical trainee ~~according to section 245.462, subdivision 17, paragraph (g)~~.

Sec. 92. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 66. **Neuropsychological assessment.** (a) "Neuropsychological assessment" means a specialized clinical assessment of the client's underlying cognitive abilities related to thinking, reasoning, and judgment that is conducted by a qualified neuropsychologist. A neuropsychological assessment must include a face-to-face interview with the client, interpretation of the test results, and preparation and completion of a report.

(b) A client is eligible for a neuropsychological assessment if at least one of the following criteria is met:

(1) there is a known or strongly suspected brain disorder based on medical history or neurological evaluation, including a history of significant head trauma, brain tumor, stroke, seizure disorder, multiple sclerosis, neurodegenerative disorder, significant exposure to neurotoxins, central nervous system infection, metabolic or toxic encephalopathy, fetal alcohol syndrome, or congenital malformation of the brain; or

(2) there are cognitive or behavioral symptoms that suggest that the client has an organic condition that cannot be readily attributed to functional psychopathology or suspected neuropsychological impairment in addition to functional psychopathology. This includes:

(i) poor memory or impaired problem solving;

(ii) change in mental status evidenced by lethargy, confusion, or disorientation;

(iii) deterioration in level of functioning;

(iv) marked behavioral or personality change;

(v) in children or adolescents, significant delays in academic skill acquisition or poor attention relative to peers;

(vi) in children or adolescents, significant plateau in expected development of cognitive, social, emotional, or physical function relative to peers; and

(vii) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands.

(c) The neuropsychological assessment must be conducted by a neuropsychologist competent in the area of neuropsychological assessment who:

(1) was awarded a diploma by the American Board of Clinical Neuropsychology, the American Board of Professional Neuropsychology, or the American Board of Pediatric Neuropsychology;

(2) earned a doctoral degree in psychology from an accredited university training program and:

(i) completed an internship or its equivalent in a clinically relevant area of professional psychology;

(ii) completed the equivalent of two full-time years of experience and specialized training, at least one of which is at the postdoctoral level, supervised by a clinical neuropsychologist in the study and practice of clinical neuropsychology and related neurosciences; and

(iii) holds a current license to practice psychology independently according to sections 144.88 to 144.98;

(3) is licensed or credentialed by another state's board of psychology examiners in the specialty of neuropsychology using requirements equivalent to requirements specified by one of the boards named in clause (1); or

(4) was approved by the commissioner as an eligible provider of neuropsychological assessment prior to December 31, 2010.

Sec. 93. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 67. **Neuropsychological testing.** (a) "Neuropsychological testing" means administering standardized tests and measures designed to evaluate the client's ability to attend to, process, interpret, comprehend, communicate, learn, and recall information and use problem solving and judgment.

(b) Medical assistance covers neuropsychological testing when the client:

(1) has a significant mental status change that is not a result of a metabolic disorder and that has failed to respond to treatment;

(2) is a child or adolescent with a significant plateau in expected development of cognitive, social, emotional, or physical function relative to peers;

(3) is a child or adolescent with a significant inability to develop expected knowledge, skills, or abilities as required to adapt to new or changing cognitive, social, physical, or emotional demands; or

(4) has a significant behavioral change, memory loss, or suspected neuropsychological impairment in addition to functional psychopathology, or other organic brain injury or one of the following:

(i) traumatic brain injury;

(ii) stroke;

(iii) brain tumor;

(iv) substance use disorder;

(v) cerebral anoxic or hypoxic episode;

(vi) central nervous system infection or other infectious disease;

(vii) neoplasms or vascular injury of the central nervous system;

(viii) neurodegenerative disorders;

(ix) demyelinating disease;

(x) extrapyramidal disease;

(xi) exposure to systemic or intrathecal agents or cranial radiation known to be associated with cerebral dysfunction;

(xii) systemic medical conditions known to be associated with cerebral dysfunction, including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and related hematologic anomalies, and autoimmune disorders, including lupus, erythematosis, or celiac disease;

(xiii) congenital genetic or metabolic disorders known to be associated with cerebral dysfunction, including phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;

(xiv) severe or prolonged nutrition or malabsorption syndromes; or

(xv) a condition presenting in a manner difficult for a clinician to distinguish between the neurocognitive effects of a neurogenic syndrome, including dementia or encephalopathy; and a major depressive disorder when adequate treatment for major depressive disorder has not resulted in improvement in neurocognitive function; or another disorder, including autism, selective mutism, anxiety disorder, or reactive attachment disorder.

(c) Neuropsychological testing must be administered or clinically supervised by a neuropsychologist qualified as defined in subdivision 66, paragraph (c).

(d) Neuropsychological testing is not covered when performed: (1) primarily for educational purposes; (2) primarily for vocational counseling or training; (3) for personnel or employment testing; (4) as a routine battery of psychological tests given at inpatient admission or during a continued stay; or (5) for legal or forensic purposes.

Sec. 94. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 68. **Psychological testing.** (a) "Psychological testing" means the use of tests or other psychometric instruments to determine the status of the client's mental, intellectual, and emotional functioning.

(b) The psychological testing must:

(1) be administered or clinically supervised by a licensed psychologist qualified according to section 245I.16, subdivision 2, clause (3), competent in the area of psychological testing; and

(2) be validated in a face-to-face interview between the client and a licensed psychologist or a clinical psychology trainee qualified according to section 245I.16, subdivision 6, under the treatment supervision of a licensed psychologist according to section 245I.18.

(c) The administration, scoring, and interpretation of the psychological tests must be done under the treatment supervision of a licensed psychologist when performed by a clinical

psychology trainee, technician, psychometrist, or psychological assistant or as part of a computer-assisted psychological testing program. The report resulting from the psychological testing must be signed by the psychologist conducting the face-to-face interview, placed in the client's record, and released to each person authorized by the client.

Sec. 95. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 69. **Psychotherapy.** (a) "Psychotherapy" means treatment of a client with mental illness that applies to the most appropriate psychological, psychiatric, psychosocial, or interpersonal method that conforms to prevailing community standards of professional practice to meet the mental health needs of the client. Medical assistance covers psychotherapy if conducted by a mental health professional qualified according to section 245I.16, subdivision 2, or a clinical trainee qualified according to section 245I.16, subdivision 6.

(b) Individual psychotherapy is psychotherapy designed for one client.

(c) Family psychotherapy is designed for the client and one or more family members or the client's primary caregiver whose participation is necessary to accomplish the client's treatment goals. Family members or primary caregivers participating in a therapy session do not need to be eligible for medical assistance. For purposes of this paragraph, "primary caregiver whose participation is necessary to accomplish the client's treatment goals" excludes shift or facility staff persons at the client's residence. Medical assistance payment for family psychotherapy is limited to face-to-face sessions at which the client is present throughout the family psychotherapy session unless the mental health professional believes the client's absence from the family psychotherapy session is necessary to carry out the client's individual treatment plan. If the client is excluded, the mental health professional must document the reason for and the length of time of the exclusion. The mental health professional must also document any reason a member of the client's family is excluded.

(d) Group psychotherapy is appropriate for a client who, because of the nature of the client's emotional, behavioral, or social dysfunctions, can derive mutual benefit from treatment in a group setting. For a group of three to eight persons, one mental health professional or clinical trainee is required to conduct the group. For a group of nine to 12 persons, a team of at least two mental health professionals or two clinical trainees or one mental health professional and one clinical trainee is required to co-conduct the group. Medical assistance payment is limited to a group of no more than 12 persons.

(e) A multiple-family group psychotherapy session is eligible for medical assistance payment if the psychotherapy session is designed for at least two but not more than five families. Multiple-family group psychotherapy is clearly directed toward meeting the identified treatment needs of each client as indicated in each client's treatment plan. If the client is excluded, the mental health professional or clinical trainee must document the reason for and the length of time of the exclusion. The mental health professional or clinical trainee must document any reason a member of the client's family is excluded.

Sec. 96. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 70. **Partial hospitalization.** "Partial hospitalization" means a provider's time-limited, structured program of psychotherapy and other therapeutic services, as defined in United States Code, title 42, chapter 7, subchapter XVIII, part E, section 1395x(ff), that is provided in an outpatient hospital facility or community mental health center that meets Medicare requirements to provide partial hospitalization services. Partial hospitalization is a covered service when it is an appropriate alternative to inpatient hospitalization for a client who is experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission under Minnesota Rules, part 9505.0520, subpart 1, and who has the family and community resources necessary and appropriate to support the client's residence in the community. Partial hospitalization consists of multiple intensive short-term therapeutic services provided by a multidisciplinary staff person to treat the client's mental illness.

Sec. 97. **[256B.0671] CLIENT ELIGIBILITY FOR MENTAL HEALTH SERVICES.**

Subdivision 1. **Definitions.** For the purposes of this section, the definitions in section 245I.02 apply.

Subd. 1a. **Generally.** (a) The provider must use a diagnostic assessment or crisis assessment to determine a client's eligibility for mental health services, except as provided in this section.

(b) Prior to completion of a client's initial diagnostic assessment, a client is eligible for:

(1) one explanation of findings;

(2) one psychological testing;

(3) any combination of individual psychotherapy sessions, family psychotherapy sessions, group psychotherapy sessions, and individual or family psychoeducation sessions not to exceed three sessions; and

(4) crisis assessment and intervention services provided according to section 256B.0624 or 256B.0944.

(c) Based on the needs identified in a crisis assessment as specified in section 256B.0624 or 256B.0944, a client may receive: (1) crisis stabilization services; and (2) any combination of individual psychotherapy sessions, family psychotherapy sessions, or family psychoeducation sessions not to exceed ten sessions within a 12-month period without prior authorization.

(d) Based on the needs identified in a brief diagnostic assessment, a client may receive a combination of individual psychotherapy sessions, family psychotherapy sessions, or family psychoeducation sessions not to exceed ten sessions within a 12-month period without prior authorization for any new client or for an existing client who is projected to need fewer than ten sessions in the next 12 months.

(e) If the amount of services or intensity required by the client exceeds the coverage limits in this section, a provider shall complete a standard diagnostic assessment.

(f) A new standard diagnostic assessment must be completed:

(1) when the client requires services of a greater number or intensity than those permitted by paragraphs (b) to (d);

(2) at least annually following the initial diagnostic assessment if additional services are needed and the client does not meet the criteria for brief assessment.

(3) when the client's mental health condition has changed markedly since the client's most recent diagnostic assessment; or

(4) when the client's current mental health condition does not meet the criteria of the client's current diagnosis.

(g) For an existing client, a new standard diagnostic assessment shall include a written update of the parts where significant new or changed information exists, and documentation where there has not been significant change, including discussion with the client about changes in the client's life situation, functioning, presenting problems, and progress on treatment goals since the last diagnostic assessment was completed.

Subd. 1b. **Continuity of services.** (a) For any client served with a diagnostic assessment completed under Minnesota Rules, parts 9505.0370 to 9505.0372, before the effective date, the diagnostic assessment is valid for purposes of authorizing treatment and billing for one calendar year after completion.

(b) For any client served with an individual treatment plan completed under section 256B.0622, 256B.0623, 256B.0943, 256B.0946, or 256B.0947 or Minnesota Rules, parts 9505.0370 to 9505.0372, the individual treatment plan is valid for purposes of authorizing treatment and billing until its expiration date.

(c) This subdivision expires July 1, 2021.

Subd. 2. **Diagnostic assessment.** To be eligible for medical assistance payment, a diagnostic assessment must (1) identify at least one mental health diagnosis and recommend mental health services to develop the client's mental health services and treatment plan, or (2) include a finding that the client does not meet the criteria for a mental health disorder.

Subd. 3. **Standard diagnostic assessment requirements.** (a) A standard diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or clinical trainee. The standard diagnostic assessment must be completed within the cultural context of the client.

(b) The clinician shall gather and document information related to the client's current life situation and the client's:

(1) age;

(2) current living situation, including household membership and housing status;

(3) basic needs status;

(4) education level and employment status;

(5) family and other significant personal relationships, including the client's evaluation of relationship quality;

(6) strengths and resources, including the extent and quality of social networks;

(7) belief systems;

(8) current medications; and

(9) immediate risks to health and safety.

(c) The clinician shall gather and document information related to the elements of the assessment, including the client's:

(1) perceptions of the client's condition;

(2) description of symptoms, including reason for referral;

(3) history of mental health treatment; and

(4) cultural influences and the impact on the client.

(d) A clinician completing a diagnostic assessment shall use professional judgment in making inquiries under this paragraph. If information cannot be obtained without retraumatizing the client or harming the client's willingness to engage in treatment, the clinician shall document which topics require further attention in the course of treatment. A clinician must, as clinically appropriate, include the following information related to a client in a diagnostic assessment:

(1) important developmental incidents;

(2) maltreatment, trauma, potential brain injuries, or abuse issues;

(3) history of alcohol and drug usage and treatment; and

(4) health history and family health history, including physical, chemical, and mental health history.

(e) The clinician must perform and document the following components of the assessment:

(1) the client's mental status examination;

(2) information gathered concerning the client's baseline measurements; symptoms; behavior; skills; abilities; resources; vulnerabilities; safety needs, including client data adequate to support findings based on the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association; and any differential diagnosis;

(3) for a child younger than 6 years of age, a clinician may use the current edition of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood instead of the Diagnostic and Statistical Manual of Mental Disorders;

(4) the screenings used to determine the client's substance use, abuse, or dependency and other standardized screening instruments determined by the commissioner;

(5) use of standardized outcome measurements by the provider as determined and periodically updated by the commissioner; and

(6) a case conceptualization that explains: (i) the diagnostic formulation made based on the information gathered through the interview, assessment, available psychological testing, and collateral information; (ii) the needs of the client; (iii) risk factors; (iv) strengths; and (v) responsivity factors.

(f) The diagnostic assessment must include recommendations, client and family participation in assessment and service preferences, and referrals to services required by law.

Subd. 4. **Brief diagnostic assessment requirements.** (a) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee. The mental health professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:

(1) age;

(2) description of symptoms, including reason for referral;

(3) history of mental health treatment;

(4) cultural influences and their impact on the client; and

(5) mental status examination.

(b) On the basis of the initial components, the mental health professional or clinical trainee must draw a provisional diagnostic formulation. The diagnostic formulation may be used to address the client's immediate needs or presenting problem.

(c) Treatment sessions conducted under authorization of a brief diagnostic assessment may be used to gather additional information necessary to complete a standard diagnostic assessment if coverage limits in subdivision 1 will be exceeded.

Subd. 5. **Individual treatment plan.** Medical assistance payment is available only for mental health services provided in accordance with the client's written individual treatment plan, with the following exceptions: (1) services that do not require a standard diagnostic assessment prior to service delivery; (2) service plan development; and (3) re-engagement of a client as described in subdivision 6, clause (6).

Subd. 6. **Individual treatment plan; required elements.** An individual treatment plan must:

(1) be based on the information in the client's diagnostic assessment and baselines;

(2) identify goals and objectives of treatment, the treatment strategy, the schedule for accomplishing treatment goals and measurable objectives, and the individuals responsible for providing treatment services and supports;

(3) be developed after completion of the client's diagnostic assessment, within three visits unless otherwise specified by a service line;

(4) for a child client, be developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessment, and treatment planning. For an adult client, the individual treatment plan must be developed through a person-centered, culturally appropriate planning process, including allowing identified supports to observe or participate in treatment services, assessment, and treatment planning;

(5) be reviewed at least every 90 days unless otherwise specified by the requirements of a service line and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment; and

(6) be approved by the client, the client's parent, another person authorized by law to consent to mental health services for the client, or a treatment plan ordered by the court under chapter 253B. If approval cannot be obtained, a mental health professional shall make efforts to obtain approval from an authorized person for a period of 30 days following the date the previous individual treatment plan expired. A client shall not be denied service in this time period solely on the basis of an unapproved individual treatment plan. A provider entity may continue to bill for otherwise eligible services during a period of re-engagement.

Sec. 98. Minnesota Statutes 2018, section 256B.0757, subdivision 2, is amended to read:

Subd. 2. **Eligible individual.** An individual is eligible for health home services under this section if the individual is eligible for medical assistance under this chapter and has at least:

(1) two chronic conditions;

(2) one chronic condition and is at risk of having a second chronic condition;

(3) one serious and persistent mental health condition; or

(4) a condition that meets the definition in section 245.462, subdivision 20, paragraph (a), or 245.4871, subdivision 15, clause (2); and has a current diagnostic assessment as ~~defined in Minnesota Rules, part 9505.0372, subpart 1, item B or C~~ that meets the requirements of section 256B.0671, subdivisions 2 and 3, as performed or reviewed by a mental health professional employed by or under contract with the behavioral health home. The commissioner shall establish criteria for determining continued eligibility.

Sec. 99. Minnesota Statutes 2018, section 256B.0941, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) An individual who is eligible for mental health treatment services in a psychiatric residential treatment facility must meet all of the following criteria:

(1) before admission, services are determined to be medically necessary by the state's medical review agent according to Code of Federal Regulations, title 42, section 441.152;

(2) is younger than 21 years of age at the time of admission. Services may continue until the individual meets criteria for discharge or reaches 22 years of age, whichever occurs first;

(3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression, or a finding that the individual is a risk to self or others;

(4) has functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; an inability to adequately care for one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill the individual's needs;

(5) requires psychiatric residential treatment under the direction of a physician to improve the individual's condition or prevent further regression so that services will no longer be needed;

(6) utilized and exhausted other community-based mental health services, or clinical evidence indicates that such services cannot provide the level of care needed; and

(7) was referred for treatment in a psychiatric residential treatment facility by a qualified mental health professional ~~licensed as defined in section 245.4871, subdivision 27, clauses (1) to (6)~~ qualified according to section 245I.16, subdivision 2.

(b) A mental health professional making a referral shall submit documentation to the state's medical review agent containing all information necessary to determine medical necessity, including a standard diagnostic assessment completed within 180 days of the individual's admission. Documentation shall include evidence of family participation in the individual's treatment planning and signed consent for services.

Sec. 100. Minnesota Statutes 2018, section 256B.0943, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention to treat a diagnosed emotional disturbance~~, as defined in section 245.4871, subdivision 15,~~ or ~~a diagnosed~~ mental illness~~, as defined in section 245.462, subdivision~~

~~20~~. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

~~(b) "Clinical supervision" means the overall responsibility of the mental health professional for the control and direction of individualized treatment planning, service delivery, and treatment review for each client. A mental health professional who is an enrolled Minnesota health care program provider accepts full professional responsibility for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the supervisee's work.~~

~~(c)~~ (b) "Clinical trainee" ~~means a mental health practitioner who meets the qualifications specified in Minnesota Rules, part 9505.0371, subpart 5, item C~~ means a staff person qualified according to section 245I.16, subdivision 6.

~~(d) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a. Crisis assistance entails the development of a written plan to assist a child's family to contend with a potential crisis and is distinct from the immediate provision of crisis intervention services.~~

(c) "Crisis planning" means the support and planning activities described under section 245.4871, subdivision 9a.

~~(e)~~ (d) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

~~(f)~~ (e) "Day treatment program" for children means a site-based structured mental health program consisting of psychotherapy for three or more individuals and individual or group skills training provided by a ~~multidisciplinary~~ treatment team, under the ~~clinical~~ treatment supervision of a mental health professional.

~~(g)~~ (f) "Diagnostic assessment" ~~has the meaning given in Minnesota Rules, part 9505.0372, subpart 1~~ means the assessment described under section 256B.0671, subdivisions 2 and 3.

~~(h)~~ (g) "Direct service time" means the time that a mental health professional, clinical trainee, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family or providing covered telemedicine services. Direct service time includes time in which the provider obtains a client's history, develops a client's

treatment plan, records individual treatment outcomes, or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling or maintaining clinical records.

~~(i)~~ (h) "Direction of mental health behavioral aide" means the activities of a mental health professional, clinical trainee, or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individualized treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (5).

~~(j)~~ (i) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15.

~~(k)~~ (j) "Individual behavioral plan" means a plan of intervention, treatment, and services for a child written by a mental health professional, clinical trainee, or mental health practitioner, under the ~~clinical~~ treatment supervision of a mental health professional, to guide the work of the mental health behavioral aide. The individual behavioral plan may be incorporated into the child's individual treatment plan so long as the behavioral plan is separately communicable to the mental health behavioral aide.

~~(l)~~ (k) "Individual treatment plan" ~~has the meaning given in Minnesota Rules, part 9505.0371, subpart 7~~ means the plan described under section 256B.0671, subdivisions 5 and 6.

~~(m)~~ (l) "Mental health behavioral aide services" means medically necessary ~~one-on-one~~ activities performed by a trained paraprofessional ~~qualified as provided in subdivision 7, paragraph (b), clause (3),~~ to assist a child retain or generalize psychosocial skills as previously trained by a mental health professional, clinical trainee, or mental health practitioner and as described in the child's individual treatment plan and individual behavior plan. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

(m) "Mental health certified family peer specialist" means a staff person qualified according to section 245I.16, subdivision 12.

(n) "Mental health practitioner" ~~has the meaning given in~~ means a staff person qualified according to section ~~245.462, subdivision 17, except that a practitioner working in a day treatment setting may qualify as a mental health practitioner if the practitioner holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university, and: (1) has at least 2,000 hours of clinically supervised experience~~

~~in the delivery of mental health services to clients with mental illness; (2) is fluent in the language, other than English, of the cultural group that makes up at least 50 percent of the practitioner's clients, completes 40 hours of training on the delivery of services to clients with mental illness, and receives clinical supervision from a mental health professional at least once per week until meeting the required 2,000 hours of supervised experience; or (3) receives 40 hours of training on the delivery of services to clients with mental illness within six months of employment, and clinical supervision from a mental health professional at least once per week until meeting the required 2,000 hours of supervised experience~~ 245I.16, subdivision 4.

(o) "Mental health professional" means ~~an individual as defined in Minnesota Rules, part 9505.0370, subpart 18~~ a staff person qualified according to section 245I.16, subdivision 2.

(p) "Mental health service plan development" includes:

(1) the development, review, and revision of a child's individual treatment plan, ~~as provided in Minnesota Rules, part 9505.0371, subpart 7~~ according to section 256B.0671, subdivisions 5 and 6, including involvement of the client or client's parents, primary caregiver, or other person authorized to consent to mental health services for the client, and including arrangement of treatment and support activities specified in the individual treatment plan; and

(2) administering standardized outcome measurement instruments, determined and updated by the commissioner, as periodically needed to evaluate the effectiveness of treatment for children receiving clinical services and reporting outcome measures, as required by the commissioner.

(q) "Mental illness," for persons at least age 18 but under age 21, has the meaning given in section 245.462, subdivision 20, paragraph (a).

(r) "Psychotherapy" means the treatment of mental or emotional disorders or maladjustment by psychological means. Psychotherapy may be provided in many modalities ~~in accordance with Minnesota Rules, part 9505.0372, subpart 6,~~ including patient and/or family psychotherapy; family psychotherapy; psychotherapy for crisis; group psychotherapy; or multiple-family psychotherapy. ~~Beginning with the American Medical Association's Current Procedural Terminology, standard edition, 2014, the procedure "individual psychotherapy" is replaced with "patient and/or family psychotherapy," a substantive change that permits the therapist to work with the client's family without the client present to obtain information about the client or to explain the client's treatment plan to the family.~~

Psychotherapy for crisis is appropriate ~~for crisis response~~ when a child has become dysregulated or experienced new trauma since the diagnostic assessment was completed and needs psychotherapy to address issues not currently included in the child's individual treatment plan.

(s) "Rehabilitative services" or "psychiatric rehabilitation services" means ~~a series or multidisciplinary combination of psychiatric and psychosocial~~ interventions to: (1) restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with, counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Psychiatric rehabilitation services for children combine coordinated psychotherapy to address internal psychological, emotional, and intellectual processing deficits, and skills training to restore personal and social functioning. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building upon a prior achievement. ~~Continuing progress toward goals is expected, and rehabilitative potential ceases when successive improvement is not observable over a period of time.~~

(t) "Skills training" means individual, family, or group training, delivered by or under the supervision of a mental health professional, designed to facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child to self-monitor, compensate for, cope with, counteract, or replace skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

(u) "Treatment supervision" means the supervision described under section 245I.18.

Sec. 101. Minnesota Statutes 2018, section 256B.0943, subdivision 2, is amended to read:

Subd. 2. **Covered service components of children's therapeutic services and supports.** (a) ~~Subject to federal approval,~~ Medical assistance covers medically necessary children's therapeutic services and supports as defined in this section that an eligible provider entity certified under subdivision 4 provides to a client eligible under subdivision 3.

(b) The service components of children's therapeutic services and supports are:

(1) patient and/or family psychotherapy, family psychotherapy, psychotherapy for crisis, and group psychotherapy;

(2) individual, family, or group skills training provided by a mental health professional or mental health practitioner;

(3) crisis ~~assistance~~ planning;

(4) mental health behavioral aide services;

(5) direction of a mental health behavioral aide;

(6) mental health service plan development; and

(7) children's day treatment.

Sec. 102. Minnesota Statutes 2018, section 256B.0943, subdivision 3, is amended to read:

Subd. 3. **Determination of client eligibility.** A client's eligibility to receive children's therapeutic services and supports under this section shall be determined based on a diagnostic assessment by a mental health professional or ~~a mental health practitioner who meets the requirements of~~ a clinical trainee ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item C,~~ that is performed within one year before the initial start of service. The diagnostic assessment must meet the requirements for a standard ~~or extended~~ diagnostic assessment ~~as defined in Minnesota Rules, part 9505.0372, subpart 1, items B and C~~, and:

(1) ~~include current diagnoses, including any differential diagnosis, in accordance with all criteria for a complete diagnosis and diagnostic profile as specified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, or,~~ for children under age ~~five, as~~ six, follow the requirements specified in the current edition of the Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood;

(2) determine whether a child under age 18 has a diagnosis of emotional disturbance or, if the person is between the ages of 18 and 21, whether the person has a mental illness;

(3) document children's therapeutic services and supports as medically necessary to address an identified disability, functional impairment, and the individual client's needs and goals; and

(4) be used in the development of the individualized treatment plan~~; and~~.

~~(5) be completed annually until age 18. For individuals between age 18 and 21, unless a client's mental health condition has changed markedly since the client's most recent diagnostic assessment, annual updating is necessary. For the purpose of this section, "updating" means an adult diagnostic update as defined in Minnesota Rules, part 9505.0371, subpart 2, item E.~~

Sec. 103. Minnesota Statutes 2018, section 256B.0943, subdivision 4, is amended to read:

Subd. 4. **Provider entity certification.** (a) The commissioner shall establish an initial provider entity application and certification process and recertification process to determine whether a provider entity has an administrative and clinical infrastructure that meets the requirements in subdivisions 5 and 6. A provider entity must be certified for the three core rehabilitation services of psychotherapy, skills training, and crisis ~~assistance~~ planning. The commissioner shall recertify a provider entity at least every three years. The commissioner shall establish a process for decertification of a provider entity and shall require corrective action, medical assistance repayment, or decertification of a provider entity that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process.

(b) For purposes of this section, a provider entity must meet all requirements in chapter 245I and be:

(1) an Indian health services facility or a facility owned and operated by a tribe or tribal organization operating as a 638 facility under Public Law 93-638 certified by the state;

(2) a county-operated entity certified by the state; or

(3) a noncounty entity certified by the state.

Sec. 104. Minnesota Statutes 2018, section 256B.0943, subdivision 5, is amended to read:

Subd. 5. **Provider entity administrative infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have an administrative infrastructure that establishes authority and accountability for decision making and oversight of functions, including finance, personnel, system management, clinical practice, and individual treatment outcomes measurement. An eligible provider entity shall demonstrate the availability, by means of employment or contract, of at least one backup mental health professional in the event of the primary mental health professional's absence. The provider must have written policies and procedures that it reviews and updates every three years and distributes to staff initially and upon each subsequent update.

(b) The administrative infrastructure written policies and procedures must be in accordance with sections 245I.10 and 245I.13 and must include:

(1) personnel procedures, including a process for: (i) recruiting, hiring, training, and retention of culturally and linguistically competent providers; (ii) conducting a criminal background check on all direct service providers and volunteers; (iii) investigating, reporting,

and acting on violations of ethical conduct standards; (iv) investigating, reporting, and acting on violations of data privacy policies that are compliant with federal and state laws; (v) utilizing volunteers, including screening applicants, training and supervising volunteers, and providing liability coverage for volunteers; and (vi) documenting that each ~~mental health professional, mental health practitioner, or mental health behavioral aide meets the applicable provider qualification criteria~~ staff person meets the applicable qualifications under section 245I.16, training criteria under ~~subdivision 8~~ section 245I.10, and ~~clinical~~ treatment supervision ~~or direction of a mental health behavioral aide~~ requirements under ~~subdivision 6~~ section 245I.18;

(2) fiscal procedures, including internal fiscal control practices and a process for collecting revenue that is compliant with federal and state laws;

(3) a client-specific treatment outcomes measurement system, including baseline measures, to measure a client's progress toward achieving mental health rehabilitation goals. ~~Effective July 1, 2017,~~ To be eligible for medical assistance payment, a provider entity must report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner; and

(4) a process to establish and maintain individual client records in accordance with section 245I.32. ~~The client's records must include:~~

~~(i) the client's personal information;~~

~~(ii) forms applicable to data privacy;~~

~~(iii) the client's diagnostic assessment, updates, results of tests, individual treatment plan, and individual behavior plan, if necessary;~~

~~(iv) documentation of service delivery as specified under subdivision 6;~~

~~(v) telephone contacts;~~

~~(vi) discharge plan; and~~

~~(vii) if applicable, insurance information.~~

(c) A provider entity that uses a restrictive procedure with a client must meet the requirements of section 245.8261.

Sec. 105. Minnesota Statutes 2018, section 256B.0943, subdivision 6, is amended to read:

Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have a clinical infrastructure that

utilizes diagnostic assessment, individualized treatment plans, service delivery, and individual treatment plan review that are culturally competent, child-centered, and family-driven to achieve maximum benefit for the client. The provider entity must review, and update as necessary, the clinical policies and procedures every three years, must distribute the policies and procedures to staff initially and upon each subsequent update, and must train staff accordingly.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for:

(1) providing or obtaining a client's diagnostic assessment, including a diagnostic assessment performed by an outside or independent clinician, that identifies acute and chronic clinical disorders, co-occurring medical conditions, and sources of psychological and environmental problems, including baselines, and a functional assessment. The functional assessment component must clearly summarize the client's individual strengths and needs. When required components of the diagnostic assessment, such as baseline measures, are not provided in an outside or independent assessment or when baseline measures cannot be attained in a ~~one-session~~ standard diagnostic assessment, the provider entity must determine the missing information within 30 days and amend the child's diagnostic assessment or incorporate the baselines into the child's individual treatment plan;

(2) developing an individual treatment plan ~~that:~~ according to section 256B.0671, subdivisions 5 and 6;

~~(i) is based on the information in the client's diagnostic assessment and baselines;~~

~~(ii) identified goals and objectives of treatment, treatment strategy, schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports;~~

~~(iii) is developed after completion of the client's diagnostic assessment by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports;~~

~~(iv) is developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessment, and treatment planning;~~

~~(v) is reviewed at least once every 90 days and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment; and~~

~~(vi) is signed by the clinical supervisor and by the client or by the client's parent or other person authorized by statute to consent to mental health services for the client. A client's parent may approve the client's individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature;~~

(3) developing an individual behavior plan that documents ~~treatment strategies~~ and describes interventions to be provided by the mental health behavioral aide. The individual behavior plan must include:

(i) detailed instructions on the ~~treatment strategies to be provided~~ psychosocial skills to be practiced;

(ii) time allocated to each ~~treatment strategy~~ intervention;

(iii) methods of documenting the child's behavior;

(iv) methods of monitoring the child's progress in reaching objectives; and

(v) goals to increase or decrease targeted behavior as identified in the individual treatment plan;

(4) providing ~~clinical~~ treatment supervision plans ~~for mental health practitioners and mental health behavioral aides~~ according to section 245I.18. ~~A mental health professional must document the clinical supervision the professional provides by cosigning individual treatment plans and making entries in the client's record on supervisory activities. The clinical supervisor also shall document supervisee-specific supervision in the supervisee's personnel file. Clinical~~ Treatment supervision does not include the authority to make or terminate court-ordered placements of the child~~. A clinical supervisor must be available for urgent consultation as required by the individual client's needs or the situation. Clinical supervision may occur individually or in a small group to discuss treatment and review progress toward goals. The focus of clinical supervision must be the client's treatment needs and progress and the mental health practitioner's or behavioral aide's ability to provide services~~;

(4a) meeting day treatment program conditions in items (i) to (iii):

(i) the ~~clinical~~ treatment supervisor must be present and available on the premises more than 50 percent of the time in a provider's standard working week during which the supervisee is providing a mental health service;

(ii) the treatment supervisor must review and approve the client's diagnosis and the client's individual treatment plan or a change in the diagnosis or individual treatment plan ~~must be made by or reviewed, approved, and signed by the clinical supervisor~~; and

(iii) every 30 days, the ~~clinical~~ treatment supervisor must review and sign the record indicating the supervisor has reviewed the client's care for all activities in the preceding 30-day period;

(4b) meeting the ~~clinical~~ treatment supervision standards in items (i) ~~to (iv)~~ and (ii) for all other services provided under CTSS:

~~(i) medical assistance shall reimburse for services provided by a mental health practitioner who is delivering services that fall within the scope of the practitioner's practice and who is supervised by a mental health professional who accepts full professional responsibility;~~

~~(ii) medical assistance shall reimburse for services provided by a mental health behavioral aide who is delivering services that fall within the scope of the aide's practice and who is supervised by a mental health professional who accepts full professional responsibility and has an approved plan for clinical supervision of the behavioral aide. Plans must be developed in accordance with supervision standards defined in Minnesota Rules, part 9505.0371, subpart 4, items A to D;~~

~~(iii)~~ (i) the mental health professional is required to be present at the site of service delivery for observation as clinically appropriate when the mental health practitioner or mental health behavioral aide is providing CTSS services; and

~~(iv)~~ (ii) when conducted, the on-site presence of the mental health professional must be documented in the child's record and signed by the mental health professional who accepts full professional responsibility;

(5) providing direction to a mental health behavioral aide. For entities that employ mental health behavioral aides, the ~~clinical~~ treatment supervisor must be employed by the provider entity or other provider certified to provide mental health behavioral aide services to ensure necessary and appropriate oversight for the client's treatment and continuity of care. The ~~mental health professional or mental health practitioner~~ staff giving direction must begin with the goals on the individualized treatment plan, and instruct the mental health behavioral aide on how to implement therapeutic activities and interventions that will lead to goal attainment. The ~~professional or practitioner~~ staff giving direction must also instruct the mental health behavioral aide about the client's diagnosis, functional status, and other characteristics that are likely to affect service delivery. Direction must also include determining that the mental health behavioral aide has the skills to interact with the client and the client's family in ways that convey personal and cultural respect and that the aide actively solicits information relevant to treatment from the family. The aide must be able to clearly explain or demonstrate the activities the aide is doing with the client and the

activities' relationship to treatment goals. Direction is more didactic than is supervision and requires the ~~professional or practitioner~~ staff providing it to continuously evaluate the mental health behavioral aide's ability to carry out the activities of the individualized treatment plan and the individualized behavior plan. When providing direction, the ~~professional or practitioner~~ staff must:

(i) review progress notes prepared by the mental health behavioral aide for accuracy and consistency with diagnostic assessment, treatment plan, and behavior goals and the professional or practitioner must approve and sign the progress notes;

(ii) identify changes in treatment strategies, revise the individual behavior plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;

(iii) demonstrate family-friendly behaviors that support healthy collaboration among the child, the child's family, and providers as treatment is planned and implemented;

(iv) ensure that the mental health behavioral aide is able to effectively communicate with the child, the child's family, and the provider; and

(v) record the results of any evaluation and corrective actions taken to modify the work of the mental health behavioral aide;

(6) providing service delivery that implements the individual treatment plan and meets the requirements under subdivision 9; and

(7) individual treatment plan review. The review must determine the extent to which the services have met each of the goals and objectives in the treatment plan. The review must assess the client's progress and ensure that services and treatment goals continue to be necessary and appropriate to the client and the client's family or foster family. ~~Revision of the individual treatment plan does not require a new diagnostic assessment unless the client's mental health status has changed markedly. The updated treatment plan must be signed by the clinical supervisor and by the client, if appropriate, and by the client's parent or other person authorized by statute to give consent to the mental health services for the child.~~

Sec. 106. Minnesota Statutes 2018, section 256B.0943, subdivision 7, is amended to read:

Subd. 7. **Qualifications of individual and team providers.** (a) An individual or team provider working within the scope of the provider's practice or qualifications may provide service components of children's therapeutic services and supports that are identified as medically necessary in a client's individual treatment plan.

(b) An individual provider must be qualified as:

(1) a mental health professional ~~as defined in subdivision 1, paragraph (o)~~; ~~or~~

(2) a mental health practitioner or clinical trainee~~. The mental health practitioner or clinical trainee must work under the clinical supervision of a mental health professional~~; ~~or~~

(3) a mental health behavioral aide ~~working under the clinical supervision of a mental health professional to implement the rehabilitative mental health services previously introduced by a mental health professional or practitioner and identified in the client's individual treatment plan and individual behavior plan.~~; or

(4) a mental health certified family peer specialist.

~~(A) A level I mental health behavioral aide must:~~

~~(i) be at least 18 years old;~~

~~(ii) have a high school diploma or commissioner of education-selected high school equivalency certification or two years of experience as a primary caregiver to a child with severe emotional disturbance within the previous ten years; and~~

~~(iii) meet preservice and continuing education requirements under subdivision 8.~~

~~(B) A level II mental health behavioral aide must:~~

~~(i) be at least 18 years old;~~

~~(ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering clinical services in the treatment of mental illness concerning children or adolescents or complete a certificate program established under subdivision 8a; and~~

~~(iii) meet preservice and continuing education requirements in subdivision 8.~~

~~(c) A day treatment multidisciplinary team must include at least one mental health professional or clinical trainee and one mental health practitioner.~~

Sec. 107. Minnesota Statutes 2018, section 256B.0943, subdivision 8, is amended to read:

Subd. 8. **Required preservice and continuing education.** ~~(a)~~ A provider entity shall establish a plan to provide preservice and continuing education for staff according to section 245I.10. ~~The plan must clearly describe the type of training necessary to maintain current skills and obtain new skills and that relates to the provider entity's goals and objectives for services offered.~~

~~(b) A provider that employs a mental health behavioral aide under this section must require the mental health behavioral aide to complete 30 hours of preservice training. The preservice training must include parent team training. The preservice training must include 15 hours of in-person training of a mental health behavioral aide in mental health services delivery and eight hours of parent team training. Curricula for parent team training must be approved in advance by the commissioner. Components of parent team training include:~~

~~(1) partnering with parents;~~

~~(2) fundamentals of family support;~~

~~(3) fundamentals of policy and decision making;~~

~~(4) defining equal partnership;~~

~~(5) complexities of the parent and service provider partnership in multiple service delivery systems due to system strengths and weaknesses;~~

~~(6) sibling impacts;~~

~~(7) support networks; and~~

~~(8) community resources.~~

~~(c) A provider entity that employs a mental health practitioner and a mental health behavioral aide to provide children's therapeutic services and supports under this section must require the mental health practitioner and mental health behavioral aide to complete 20 hours of continuing education every two calendar years. The continuing education must be related to serving the needs of a child with emotional disturbance in the child's home environment and the child's family.~~

~~(d) The provider entity must document the mental health practitioner's or mental health behavioral aide's annual completion of the required continuing education. The documentation must include the date, subject, and number of hours of the continuing education, and attendance records, as verified by the staff member's signature, job title, and the instructor's name. The provider entity must keep documentation for each employee, including records of attendance at professional workshops and conferences, at a central location and in the employee's personnel file.~~

Sec. 108. Minnesota Statutes 2018, section 256B.0943, subdivision 9, is amended to read:

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) ~~each individual provider's caseload size permits the provider to deliver services to both clients with severe, complex needs and clients with less intensive needs.~~ the provider's caseload size ~~should~~ reasonably ~~enable~~ enables the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan; and

(3) a day treatment program is provided to a group of clients by a ~~multidisciplinary~~ team under the ~~clinical~~ treatment supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that is certified under subdivision 4 to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The program must be available year-round at least three to five days per week, two or three hours per day, unless the normal five-day school week is shortened by a holiday, weather-related cancellation, or other districtwide reduction in a school week. A child transitioning into or out of day treatment must receive a minimum treatment of one day a week for a two-hour time block. The two-hour time block must include at least one hour of patient and/or family or group psychotherapy. The remainder of the structured treatment program may include patient and/or family or group psychotherapy, and individual or group skills training, if included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services. When a day treatment group that meets the minimum group size requirement temporarily falls below the minimum group size because of a member's temporary absence, medical assistance covers a group session conducted for the group members in attendance. A day treatment program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program.

(b) To be eligible for medical assistance payment, a provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) patient and/or family, family, and group psychotherapy must be delivered as specified in ~~Minnesota Rules, part 9505.0372, subpart 6~~ section 256B.0625, subdivision 69. Psychotherapy to address the child's underlying mental health disorder must be documented as part of the child's ongoing treatment. A provider must deliver, or arrange for, medically necessary psychotherapy, unless the child's parent or caregiver chooses not to receive it. When a provider delivering other services to a child under this section deems it not medically necessary to provide psychotherapy to the child for a period of 90 days or longer, the provider entity must document the medical reasons why psychotherapy is not necessary. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record;

(2) individual, family, or group skills training ~~must be provided by a mental health professional or a mental health practitioner who is delivering services that fall within the scope of the provider's practice and is supervised by a mental health professional who accepts full professional responsibility for the training. Skills training~~ is subject to the following requirements:

(i) a mental health professional, clinical trainee, or mental health practitioner shall provide skills training;

(ii) skills training delivered to a child or the child's family must be targeted to the specific deficits or maladaptations of the child's mental health disorder and must be prescribed in the child's individual treatment plan;

(iii) the mental health professional delivering or supervising the delivery of skills training must document any underlying psychiatric condition and must document how skills training is being used in conjunction with psychotherapy to address the underlying condition;

(iv) skills training delivered to the child's family must teach skills needed by parents or primary caregivers to enhance the child's skill development, to help the child utilize daily life skills taught by a mental health professional, clinical trainee, or mental health practitioner, and to develop or maintain a home environment that supports the child's progressive use of skills;

(v) group skills training may be provided to multiple recipients who, because of the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting, which must be staffed as follows:

(A) one mental health professional or one clinical trainee or mental health practitioner ~~under supervision of a licensed mental health professional~~ must work with a group of three to eight clients; or

(B) any combination of two mental health professionals, ~~two~~ clinical trainees, or mental health practitioners ~~under supervision of a licensed mental health professional, or one mental health professional or clinical trainee and one mental health practitioner~~ must work with a group of nine to 12 clients;

(vi) a mental health professional, clinical trainee, or mental health practitioner must have taught the psychosocial skill before a mental health behavioral aide may practice that skill with the client; and

(vii) for group skills training, when a skills group that meets the minimum group size requirement temporarily falls below the minimum group size because of a group member's temporary absence, the provider may conduct the session for the group members in attendance;

(3) crisis ~~assistance~~ planning to a child and family must include development of a written plan that anticipates the particular factors specific to the child that may precipitate a psychiatric crisis for the child in the near future. The written plan must document actions that the family should be prepared to take to resolve or stabilize a crisis, such as advance arrangements for direct intervention and support services to the child and the child's family. Crisis ~~assistance~~ planning must include preparing resources designed to address abrupt or substantial changes in the functioning of the child or the child's family when sudden change in behavior or a loss of usual coping mechanisms is observed, or the child begins to present a danger to self or others;

(4) mental health behavioral aide services must be medically necessary treatment services, identified in the child's individual treatment plan and individual behavior plan, ~~which are performed minimally by a paraprofessional qualified according to subdivision 7, paragraph (b), clause (3), and~~ which are designed to improve the functioning of the child in the progressive use of developmentally appropriate psychosocial skills. Activities involve working directly with the child, child-peer groupings, or child-family groupings to practice, repeat, reintroduce, and master the skills defined in subdivision 1, paragraph (t), as previously taught by a mental health professional, clinical trainee, or mental health practitioner including:

(i) providing cues or prompts in skill-building peer-to-peer or parent-child interactions so that the child progressively recognizes and responds to the cues independently;

(ii) performing as a practice partner or role-play partner;

(iii) reinforcing the child's accomplishments;

(iv) generalizing skill-building activities in the child's multiple natural settings;

(v) assigning further practice activities; and

(vi) intervening as necessary to redirect the child's target behavior and to de-escalate behavior that puts the child or other person at risk of injury.

To be eligible for medical assistance payment, mental health behavioral aide services must be delivered to a child who has been diagnosed with an emotional disturbance or a mental illness, as provided in subdivision 1, paragraph (a). The mental health behavioral aide must implement treatment strategies in the individual treatment plan and the individual behavior plan as developed by the mental health professional, clinical trainee, or mental health practitioner providing direction for the mental health behavioral aide. The mental health behavioral aide must document the delivery of services in written progress notes. Progress notes must reflect implementation of the treatment strategies, as performed by the mental health behavioral aide and the child's responses to the treatment strategies;

(5) direction of a mental health behavioral aide must include ~~the following:~~

~~(i) ongoing face-to-face observation of the mental health behavioral aide delivering services to a child by a mental health professional or mental health practitioner for at least a total of one hour during every 40 hours of service provided to a child; and~~

~~(ii)~~ immediate accessibility of the mental health professional, clinical trainee, or mental health practitioner to the mental health behavioral aide during service provision; and

(6) mental health service plan development must be performed in consultation with the child's family and, when appropriate, with other key participants in the child's life by the child's treating mental health professional or clinical trainee or by a mental health practitioner and approved by the treating mental health professional. Treatment plan drafting consists of development, review, and revision by face-to-face or electronic communication. The provider must document events, including the time spent with the family and other key participants in the child's life to ~~review, revise, and sign~~ approve the individual treatment plan. ~~Notwithstanding Minnesota Rules, part 9505.0371, subpart 7, medical assistance covers service plan development before completion of the child's individual treatment plan.~~ Service plan development is covered only if a treatment plan is completed for the child. If

upon review it is determined that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development~~; and~~.

~~(7) to be eligible for payment, a diagnostic assessment must be complete with regard to all required components, including multiple assessment appointments required for an extended diagnostic assessment and the written report. Dates of the multiple assessment appointments must be noted in the client's clinical record.~~

Sec. 109. Minnesota Statutes 2018, section 256B.0943, subdivision 11, is amended to read:

Subd. 11. **Documentation and billing.** (a) A provider entity must document the services it provides under this section according to section 245I.33. ~~The provider entity must ensure that documentation complies with Minnesota Rules, parts 9505.2175 and 9505.2197. Services billed under this section that are not documented according to this subdivision shall be subject to monetary recovery by the commissioner. Billing for covered service components under subdivision 2, paragraph (b), must not include anything other than direct service time.~~

~~(b) An individual mental health provider must promptly document the following in a client's record after providing services to the client:~~

~~(1) each occurrence of the client's mental health service, including the date, type, start and stop times, scope of the service as described in the child's individual treatment plan, and outcome of the service compared to baselines and objectives;~~

~~(2) the name, dated signature, and credentials of the person who delivered the service;~~

~~(3) contact made with other persons interested in the client, including representatives of the courts, corrections systems, or schools. The provider must document the name and date of each contact;~~

~~(4) any contact made with the client's other mental health providers, case manager, family members, primary caregiver, legal representative, or the reason the provider did not contact the client's family members, primary caregiver, or legal representative, if applicable;~~

~~(5) required clinical supervision directly related to the identified client's services and needs, as appropriate, with co-signatures of the supervisor and supervisee; and~~

~~(6) the date when services are discontinued and reasons for discontinuation of services.~~

Sec. 110. Minnesota Statutes 2018, section 256B.0944, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Mental health crisis" means a child's behavioral, emotional, or psychiatric situation that, but for the provision of crisis response services to the child, would likely result in significantly reduced levels of functioning in primary activities of daily living, an emergency situation, or the child's placement in a more restrictive setting, including, but not limited to, inpatient hospitalization.

(b) "Mental health emergency" means a child's behavioral, emotional, or psychiatric situation that causes an immediate need for mental health services and is consistent with section 62Q.55. A physician, mental health professional, or ~~crisis mental health practitioner~~ qualified member of a crisis team determines a mental health crisis or emergency for medical assistance reimbursement with input from the client and the client's family, if possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, mental health professional, or ~~mental health practitioner under the clinical supervision of a mental health professional~~ qualified member of a crisis team, following a screening that suggests the child may be experiencing a mental health crisis or mental health emergency situation.

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency. Mental health mobile crisis services must help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning. Mental health mobile services ~~must be provided on site by a mobile crisis intervention team outside of an emergency room, urgent care, or an inpatient hospital setting.~~, including screening and treatment plan recommendations, must be culturally and linguistically appropriate.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services that are designed to restore the recipient to the recipient's prior functional level. The individual treatment plan recommending mental health crisis stabilization must be completed by the intervention team or by staff after an inpatient or urgent care visit. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, schools, another community setting, or a short-term supervised, licensed residential program if the service is not included in the facility's cost pool or per diem. Mental health

crisis stabilization is not reimbursable when provided as part of a partial hospitalization or day treatment program.

(f) "Clinical trainee" means a person qualified according to section 245I.16, subdivision 6.

(g) "Mental health certified family peer specialist" means a person qualified according to section 245I.16, subdivision 12.

(h) "Mental health practitioner" means a person qualified according to section 245I.16, subdivision 4.

(i) "Mental health professional" means a person qualified according to section 245I.16, subdivision 2.

Sec. 111. Minnesota Statutes 2018, section 256B.0944, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is eligible for medical assistance;

(2) is under age 18 or between the ages of 18 and 21;

(3) is screened as possibly experiencing a mental health crisis or mental health emergency where a mental health crisis assessment is needed; and

(4) is assessed as experiencing a mental health crisis or mental health emergency, and mental health mobile crisis intervention or mental health crisis stabilization services are determined to be medically necessary~~; and~~.

~~(5) meets the criteria for emotional disturbance or mental illness.~~

Sec. 112. Minnesota Statutes 2018, section 256B.0944, subdivision 4, is amended to read:

Subd. 4. **Provider entity standards.** ~~(a)~~ A crisis intervention and crisis stabilization provider entity must meet the administrative and clinical standards specified in ~~section 256B.0943, subdivisions 5 and 6, meet the standards listed in paragraph (b), and be:~~ section 256B.0624, subdivision 4, and ensure services are developmentally appropriate and responsive to the needs of the families.

~~(1) an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law 93-638 as a 638 facility;~~

~~(2) a county board-operated entity; or~~

~~(3) a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring.~~

~~(b) The children's mental health crisis response services provider entity must:~~

~~(1) ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;~~

~~(2) directly provide the services or, if services are subcontracted, the provider entity must maintain clinical responsibility for services and billing;~~

~~(3) ensure that crisis intervention services are provided in a manner consistent with sections 245.487 to 245.4889; and~~

~~(4) develop and maintain written policies and procedures regarding service provision that include safety of staff and recipients in high-risk situations.~~

Sec. 113. Minnesota Statutes 2018, section 256B.0944, subdivision 5, is amended to read:

Subd. 5. **Mobile crisis intervention staff qualifications.** ~~(a) To provide children's mental health mobile crisis intervention services, a mobile crisis intervention team must include:~~

~~(1) at least two mental health professionals as defined in section 256B.0943, subdivision 1, paragraph (o); or~~

~~(2) a combination of at least one mental health professional and one mental health practitioner as defined in section 245.4871, subdivision 26, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team.~~ (a) Mobile crisis intervention team staff must be qualified to provide services as mental health professionals, mental health practitioners, clinical trainees, or mental health certified family peer specialists.

(b) A mobile crisis intervention team is comprised of at least two members, one of whom must be qualified as a mental health professional. A second member must be qualified as a mental health professional, clinical trainee, or mental health practitioner. Additional staff must be added to reflect the needs of the area served.

(c) Mental health crisis assessment and intervention services must be led by a mental health professional, or under the supervision of a mental health professional according to subdivision 9, by a clinical trainee or mental health practitioner.

~~(b)~~ (d) The team must have ~~at least two people with~~ at least one member providing on-site crisis intervention services when needed. Team members must be experienced in

mental health assessment, crisis intervention techniques, and clinical decision making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources, including the county social services agency, mental health service providers, and local law enforcement, if necessary.

Sec. 114. Minnesota Statutes 2018, section 256B.0944, subdivision 6, is amended to read:

Subd. 6. **Initial screening and crisis assessment planning.** (a) Before initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.4871, subdivision 14, and 245.4879, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify the parties involved, and determine an appropriate response.

(b) In conducting the screening, a provider shall:

(1) employ evidence-based practices as identified by the commissioner in collaboration with the commissioner of health to reduce the risk of the recipient's suicide and self-injurious behavior;

(2) work with the recipient to establish a plan and time frame for responding to the crisis, including immediate needs for support by telephone or text message until a face-to-face response arrives;

(3) document significant factors related to the determination of a crisis, including prior calls to the crisis team, recent presentation at an emergency department, known calls to 911 or law enforcement, or the presence of third parties with knowledge of a potential recipient's history or current needs;

(4) screen for the needs of a third-party caller, including a recipient who primarily identifies as a family member or a caregiver but also presents signs of a crisis; and

(5) provide psychoeducation, including education on the available means for reducing self-harm, to relevant third parties, including family members or other persons living in the home.

(c) A provider entity shall consider the following to indicate a positive screening unless the provider entity documents specific evidence to show why crisis response was clinically inappropriate:

(1) the recipient presented in an emergency department or urgent care setting, and the health care team at that location requested crisis services;

(2) a peace officer requested crisis services for a recipient who may be subject to transportation under section 253B.05 for a mental health crisis.

~~(b)~~ (d) If a crisis exists, a crisis assessment must be completed. A crisis assessment must evaluate any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, health information including current medications, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning.

~~(c)~~ (e) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As the opportunity presents itself during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek ~~clinical~~ treatment supervision as required under subdivision 9.

(f) Direct contact with the recipient is not required before initiating a crisis assessment or intervention service. A crisis team may gather relevant information from a third party at the scene to establish the need for services and potential safety factors. A crisis assessment is provided face-to-face by a mobile crisis intervention team outside of an inpatient hospital setting. A service must be provided promptly and respond to the recipient's location whenever possible, including community or clinical settings. As clinically appropriate, a mobile crisis intervention team must coordinate a response with other health care providers if a recipient requires detoxification, withdrawal management, or medical stabilization services in addition to crisis services.

~~(d)~~ (g) The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The crisis treatment plan must be updated as needed to reflect current goals and services. The team must involve the client and the client's family in developing and implementing the plan.

~~(e)~~ (h) The team must document in progress notes which short-term goals have been met and when no further crisis intervention services are required. If after an assessment a

crisis provider entity refers a recipient to an intensive setting, including an emergency department, in-patient hospitalization, or residential treatment, one of the crisis team members who performed or conferred on the assessment must immediately contact the provider entity and consult with the triage nurse or other staff responsible for intake. The crisis team member must convey key findings or concerns that led to the referral. The consultation must occur with the recipient's consent, the recipient's legal guardian's consent, or as allowed by section 144.293, subdivision 5. Any available written documentation, including a crisis treatment plan, must be sent no later than the next business day.

~~(f)~~ (i) If the client's crisis is stabilized, but the client needs a referral for mental health crisis stabilization services or to other services, the team must provide a referral to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager.

(j) If an intervention service is provided without the recipient present, the provider shall document the reasons why the service is more effective without the recipient present.

Sec. 115. Minnesota Statutes 2018, section 256B.0944, subdivision 7, is amended to read:

Subd. 7. **Crisis stabilization services.** Crisis stabilization services ~~must be provided by a mental health professional or a mental health practitioner, as defined in section 245.462, subdivision 17, who works under the clinical supervision of a mental health professional and for a crisis stabilization services provider entity and~~ must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 8;

(2) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community; and

~~(3) mental health practitioners must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.~~

(3) if an intervention is provided without the recipient present, the provider shall document the reasons why the intervention is more effective without the recipient present.

Sec. 116. Minnesota Statutes 2018, section 256B.0944, subdivision 8, is amended to read:

Subd. 8. **Treatment plan.** (a) The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement of the goals;

(4) specific objectives directed toward the achievement of each goal;

(5) documentation of the participants involved in the service planning;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur; and

(8) clear progress notes on the outcome of goals.

(b) The client, if clinically appropriate, must be a participant in the development of the crisis stabilization treatment plan. The client or the client's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the client and the client's legal guardian. The plan should include services arranged, including specific providers where applicable.

(c) A treatment plan must be developed by a mental health professional, clinical trainee, or mental health practitioner ~~under the clinical supervision of a mental health professional~~. A written plan must be completed within 24 hours of beginning services with the client.

Sec. 117. Minnesota Statutes 2018, section 256B.0944, subdivision 9, is amended to read:

Subd. 9. **Supervision.** ~~(a)~~ A mental health practitioner or clinical trainee may provide crisis assessment and mobile crisis intervention services if the following ~~clinical~~ treatment supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by telephone or in person for ~~clinical~~ treatment supervision;

(3) the mental health professional is consulted, in person or by telephone, during the first three hours when a mental health practitioner provides on-site service; and

(4) the mental health professional must review and approve the tentative crisis assessment and crisis treatment plan, document the consultation, and sign the crisis assessment and treatment plan within the next business day.

~~(b) If the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the client face-to-face on the second day to provide services and update the crisis treatment plan. The on-site observation must be documented in the client's record and signed by the mental health professional.~~

Sec. 118. Minnesota Statutes 2018, section 256B.0946, subdivision 1, is amended to read:

Subdivision 1. **Required covered service components.** (a) ~~Effective May 23, 2013, and subject to federal approval,~~ Medical assistance covers medically necessary intensive treatment services described under paragraph (b) that are provided by a provider entity eligible under subdivision 3 to a client eligible under subdivision 2 who is placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or placed in a foster home licensed under the regulations established by a federally recognized Minnesota tribe.

(b) Intensive treatment services to children with mental illness residing in foster family settings that comprise specific required service components provided in clauses (1) to (5) are reimbursed by medical assistance when they meet the following standards:

(1) psychotherapy provided by a mental health professional ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item A,~~ or a clinical trainee~~, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C~~;

(2) crisis ~~assistance~~ planning provided according to standards for children's therapeutic services and supports in section 256B.0943;

(3) individual, family, and group psychoeducation services, defined in subdivision 1a, paragraph ~~(q)~~ (o), provided by a mental health professional or a clinical trainee;

(4) clinical care consultation, as defined in subdivision 1a, and provided by a mental health professional or a clinical trainee; and

(5) service delivery payment requirements as provided under subdivision 4.

Sec. 119. Minnesota Statutes 2018, section 256B.0946, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** For the purposes of this section, the following terms have the meanings given them.

(a) "Clinical care consultation" means communication from a treating clinician to other providers working with the same client to inform, inquire, and instruct regarding the client's symptoms, strategies for effective engagement, care and intervention needs, and treatment

expectations across service settings, including but not limited to the client's school, social services, day care, probation, home, primary care, medication prescribers, disabilities services, and other mental health providers and to direct and coordinate clinical service components provided to the client and family.

~~(b) "Clinical supervision" means the documented time a clinical supervisor and supervisee spend together to discuss the supervisee's work, to review individual client cases, and for the supervisee's professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a client's mental health treatment.~~

~~(c) "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.~~

~~(d)~~ (b) "Clinical trainee" ~~has the meaning given in Minnesota Rules, part 9505.0371, subpart 5, item C~~ means a staff person qualified according to section 245I.16, subdivision 6;

~~(e)~~ (c) "Crisis ~~assistance~~ planning" has the meaning given in section 245.4871, subdivision 9a, including the development of a plan that addresses prevention and intervention strategies to be used in a potential crisis, but does not include actual crisis intervention.

~~(f)~~ (d) "Culturally appropriate" means providing mental health services in a manner that incorporates the child's cultural influences~~, as defined in Minnesota Rules, part 9505.0370, subpart 9,~~ into interventions as a way to maximize resiliency factors and utilize cultural strengths and resources to promote overall wellness.

~~(g)~~ (e) "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

~~(h)~~ (f) "Diagnostic assessment" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 11~~ means an assessment described under section 256B.0671, subdivisions 2 and 3.

~~(i)~~ (g) "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, foster parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, persons who are a part of the client's permanency plan, or persons who are presently residing together as a family unit.

~~(j)~~ (h) "Foster care" has the meaning given in section 260C.007, subdivision 18.

~~(k)~~ (i) "Foster family setting" means the foster home in which the license holder resides.

~~(l)~~ (j) "Individual treatment plan" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 15~~ means the plan described under section 256B.0671, subdivisions 5 and 6.

~~(m) "Mental health practitioner" has the meaning given in section 245.462, subdivision 17, and a mental health practitioner working as a clinical trainee according to Minnesota Rules, part 9505.0371, subpart 5, item C.~~

(k) "Mental health certified family peer specialist" means a staff person qualified according to section 245I.16, subdivision 12.

~~(n)~~ (1) "Mental health professional" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 18~~ means a staff person qualified according to section 245I.16, subdivision 2.

~~(o)~~ (m) "Mental illness" has the meaning given in ~~Minnesota Rules, part 9505.0370, subpart 20~~ section 245.462, subdivision 20, paragraph (a), and includes emotional disturbance as defined in section 245.4871, subdivision 15.

~~(p)~~ (n) "Parent" has the meaning given in section 260C.007, subdivision 25.

~~(q)~~ (o) "Psychoeducation services" means information or demonstration provided to an individual, family, or group to explain, educate, and support the individual, family, or group in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

~~(r)~~ (p) "Psychotherapy" has the meaning given in ~~Minnesota Rules, part 9505.0370, subpart 27~~ section 256B.0625, subdivision 69.

~~(s)~~ (q) "Team consultation and treatment planning" means the coordination of treatment plans and consultation among providers in a group concerning the treatment needs of the child, including disseminating the child's treatment service schedule to all members of the service team. Team members must include all mental health professionals working with the child, a parent, the child unless the team lead or parent deem it clinically inappropriate, and at least two of the following: an individualized education program case manager; probation agent; children's mental health case manager; child welfare worker, including adoption or guardianship worker; primary care provider; foster parent; and any other member of the child's service team.

(r) "Trauma" has the meaning given in section 245I.02, subdivision 24.

(s) "Treatment supervision" means the supervision described under section 245I.18.

(t) "Treatment supervisor" means the mental health professional who is responsible for treatment supervision.

Sec. 120. Minnesota Statutes 2018, section 256B.0946, subdivision 2, is amended to read:

Subd. 2. **Determination of client eligibility.** (a) An eligible recipient is an individual, from birth through age 20, who is currently placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, and has received a diagnostic assessment and an evaluation of level of care needed, as defined in paragraphs ~~(a)~~ (b) and ~~(b)~~ (c).

~~(a)~~ (b) The diagnostic assessment must:

~~(1) meet criteria described in Minnesota Rules, part 9505.0372, subpart 1, and be conducted by a mental health professional or a clinical trainee;~~

~~(2) determine whether or not a child meets the criteria for mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20;~~

~~(3)~~ (1) document that intensive treatment services are medically necessary within a foster family setting to ameliorate identified symptoms and functional impairments; and

~~(4)~~ (2) be performed within 180 days before the start of service~~; and~~.

~~(5) be completed as either a standard or extended diagnostic assessment annually to determine continued eligibility for the service.~~

~~(b)~~ (c) The evaluation of level of care must be conducted by the placing county, tribe, or case manager in conjunction with the diagnostic assessment ~~as described by Minnesota Rules, part 9505.0372, subpart 1, item B~~, using a validated tool approved by the commissioner of human services and not subject to the rulemaking process, consistent with section 245.4885, subdivision 1, paragraph (d), the result of which evaluation demonstrates that the child requires intensive intervention without 24-hour medical monitoring. The commissioner shall update the list of approved level of care tools annually and publish on the department's website.

Sec. 121. Minnesota Statutes 2018, section 256B.0946, subdivision 3, is amended to read:

Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for intensive children's mental health services in a foster family setting must be certified by the state and have a service provision contract with a county board or a reservation tribal council and

must be able to demonstrate the ability to provide all of the services required in this section and meet the requirements under chapter 245I.

(b) For purposes of this section, a provider agency must be:

(1) a county-operated entity certified by the state;

(2) an Indian Health Services facility operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or

(3) a noncounty entity.

(c) Certified providers that do not meet the service delivery standards required in this section shall be subject to a decertification process.

(d) For the purposes of this section, all services delivered to a client must be provided by a mental health professional ~~or~~, a clinical trainee, or a mental health certified family peer specialist.

Sec. 122. Minnesota Statutes 2018, section 256B.0946, subdivision 4, is amended to read:

Subd. 4. **Service delivery payment requirements.** (a) To be eligible for payment under this section, a provider must develop and practice written policies and procedures for intensive treatment in foster care, consistent with subdivision 1, paragraph (b), and comply with the following requirements in paragraphs (b) to ~~(n)~~ (m).

~~(b) A qualified clinical supervisor, as defined in and performing in compliance with Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and provision of services described in this section.~~

~~(c) Each client receiving treatment services must receive an extended diagnostic assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within 30 days of enrollment in this service unless the client has a previous extended diagnostic assessment that the client, parent, and mental health professional agree still accurately describes the client's current mental health functioning.~~

(b) For children under age six, each client must receive a diagnostic assessment according to the requirements in the current edition of the Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood.

~~(d)~~ (c) Each previous and current mental health, school, and physical health treatment provider must be contacted to request documentation of treatment and assessments that the

eligible client has received. This information must be reviewed and incorporated into the diagnostic assessment and team consultation and treatment planning review process.

~~(e)~~ (d) Each client receiving treatment must be assessed for a trauma history, and the client's treatment plan must document how the results of the assessment will be incorporated into treatment.

~~(f)~~ (e) Each client receiving treatment services must have an individual treatment plan that is reviewed, evaluated, and ~~signed~~ approved every 90 days using the team consultation and treatment planning process, as defined in subdivision 1a, paragraph ~~(s)~~ (p).

~~(g)~~ (f) Clinical care consultation, as defined in subdivision 1a, paragraph (a), must be provided in accordance with the client's individual treatment plan.

~~(h)~~ (g) Each client must have a crisis ~~assistance~~ plan within ten days of initiating services and must have access to clinical phone support 24 hours per day, seven days per week, during the course of treatment. The crisis plan must demonstrate coordination with the local or regional mobile crisis intervention team.

~~(i)~~ (h) Services must be delivered and documented at least three days per week, equaling at least six hours of treatment per week, unless reduced units of service are specified on the treatment plan as part of transition or on a discharge plan to another service or level of care. ~~Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.~~

~~(j)~~ (i) Location of service delivery must be in the client's home, day care setting, school, or other community-based setting that is specified on the client's individualized treatment plan.

~~(k)~~ (j) Treatment must be developmentally and culturally appropriate for the client.

~~(l)~~ (k) Services must be delivered in continual collaboration and consultation with the client's medical providers and, in particular, with prescribers of psychotropic medications, including those prescribed on an off-label basis. Members of the service team must be aware of the medication regimen and potential side effects.

~~(m)~~ (l) Parents, siblings, foster parents, and members of the child's permanency plan must be involved in treatment and service delivery unless otherwise noted in the treatment plan.

~~(n)~~ (m) Transition planning for the child must be conducted starting with the first treatment plan and must be addressed throughout treatment to support the child's permanency plan and postdischarge mental health service needs.

Sec. 123. Minnesota Statutes 2018, section 256B.0946, subdivision 6, is amended to read:

Subd. 6. **Excluded services.** (a) Services in clauses (1) to (7) are not covered under this section and are not eligible for medical assistance payment as components of intensive treatment in foster care services, but may be billed separately:

(1) inpatient psychiatric hospital treatment;

(2) mental health targeted case management;

(3) partial hospitalization;

(4) medication management;

(5) children's mental health day treatment services;

(6) crisis response services under section 256B.0944; and

(7) transportation.

(b) Children receiving intensive treatment in foster care services are not eligible for medical assistance reimbursement for the following services while receiving intensive treatment in foster care:

(1) psychotherapy and skills training components of children's therapeutic services and supports under section 256B.0625, subdivision 35b;

(2) mental health behavioral aide services as defined in section 256B.0943, subdivision 1, paragraph ~~(m)~~ (l);

(3) home and community-based waiver services;

(4) mental health residential treatment; and

(5) room and board costs as defined in section 256I.03, subdivision 6.

Sec. 124. Minnesota Statutes 2018, section 256B.0947, subdivision 1, is amended to read:

Subdivision 1. **Scope.** ~~Effective November 1, 2011, and subject to federal approval,~~ Medical assistance covers medically necessary, intensive nonresidential rehabilitative mental health services as defined in subdivision 2, for recipients as defined in subdivision 3, when the services are provided by an entity meeting the standards in this section.

Sec. 125. Minnesota Statutes 2018, section 256B.0947, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Intensive nonresidential rehabilitative mental health services" means child rehabilitative mental health services as defined in section 256B.0943, except that these services are provided by a multidisciplinary staff using ~~a total team~~ an approach consistent with assertive community treatment, as adapted for youth, and are directed to recipients ~~ages 16, 17, 18, 19, or 20 with a serious mental illness or co-occurring mental illness and substance abuse addiction~~ who require intensive services to prevent admission to an inpatient psychiatric hospital or placement in a residential treatment facility or who require intensive services to step down from inpatient or residential care to community-based care.

(b) "Co-occurring mental illness and substance abuse addiction" means a dual diagnosis of at least one form of mental illness and at least one substance use disorder. Substance use disorders include alcohol or drug abuse or dependence, excluding nicotine use.

(c) "Diagnostic assessment" ~~has the meaning given to it in Minnesota Rules, part 9505.0370, subpart 11. A diagnostic assessment must be provided according to Minnesota Rules, part 9505.0372, subpart 1,~~ means the assessment described under section 256B.0671, subdivisions 2 and 3, and for this section must incorporate a determination of the youth's necessary level of care using a standardized functional assessment instrument approved and periodically updated by the commissioner.

(d) "Education specialist" means an individual with knowledge and experience working with youth regarding special education requirements and goals, special education plans, and coordination of educational activities with health care activities.

(e) "Housing access support" means an ancillary activity to help an individual find, obtain, retain, and move to safe and adequate housing. Housing access support does not provide monetary assistance for rent, damage deposits, or application fees.

(f) "Integrated dual disorders treatment" means the integrated treatment of co-occurring mental illness and substance use disorders by a team of cross-trained clinicians within the same program, and is characterized by assertive outreach, stage-wise comprehensive treatment, treatment goal setting, and flexibility to work within each stage of treatment.

(g) "Medication education services" means services provided individually or in groups, which focus on:

(1) educating the client and client's family or significant nonfamilial supporters about mental illness and symptoms;

(2) the role and effects of medications in treating symptoms of mental illness; and

(3) the side effects of medications.

Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, or registered nurses with certification in psychiatric and mental health care.

(h) "Peer specialist" means an employed team member who is a mental health certified peer specialist according to section 256B.0615 and also a former children's mental health consumer ~~who:~~.

~~(1) provides direct services to clients including social, emotional, and instrumental support and outreach;~~

~~(2) assists younger peers to identify and achieve specific life goals;~~

~~(3) works directly with clients to promote the client's self-determination, personal responsibility, and empowerment;~~

~~(4) assists youth with mental illness to regain control over their lives and their developmental process in order to move effectively into adulthood;~~

~~(5) provides training and education to other team members, consumer advocacy organizations, and clients on resiliency and peer support; and~~

~~(6) meets the following criteria:~~

~~(i) is at least 22 years of age;~~

~~(ii) has had a diagnosis of mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20, or co-occurring mental illness and substance abuse addiction;~~

~~(iii) is a former consumer of child and adolescent mental health services, or a former or current consumer of adult mental health services for a period of at least two years;~~

~~(iv) has at least a high school diploma or equivalent;~~

~~(v) has successfully completed training requirements determined and periodically updated by the commissioner;~~

~~(vi) is willing to disclose the individual's own mental health history to team members and clients; and~~

~~(vii) must be free of substance use problems for at least one year.~~

~~(i) "Provider agency" means a for-profit or nonprofit organization established to administer an assertive community treatment for youth team.~~

~~(j)~~ (i) "Substance use disorders" means one or more of the disorders defined in the Diagnostic and Statistical Manual of Mental Disorders, current edition.

~~(k)~~ (j) "Transition services" means:

(1) activities, materials, consultation, and coordination that ensures continuity of the client's care in advance of and in preparation for the client's move from one stage of care or life to another by maintaining contact with the client and assisting the client to establish provider relationships;

(2) providing the client with knowledge and skills needed posttransition;

(3) establishing communication between sending and receiving entities;

(4) supporting a client's request for service authorization and enrollment; and

(5) establishing and enforcing procedures and schedules.

A youth's transition from the children's mental health system and services to the adult mental health system and services and return to the client's home and entry or re-entry into community-based mental health services following discharge from an out-of-home placement or inpatient hospital stay.

~~(l)~~ (k) "Treatment team" means all staff who provide services to recipients under this section.

Sec. 126. Minnesota Statutes 2018, section 256B.0947, subdivision 3, is amended to read:

Subd. 3. **Client eligibility.** An eligible recipient is an individual who:

(1) is age 16, 17, 18, 19, or 20; and

(2) is diagnosed with a serious mental illness or co-occurring mental illness and substance abuse addiction, for which intensive nonresidential rehabilitative mental health services are needed;

(3) has received a level-of-care determination, using an instrument approved by the commissioner, that indicates a need for intensive integrated intervention without 24-hour medical monitoring and a need for extensive collaboration among multiple providers;

(4) has a functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; or who is likely to need services from the adult mental health system within the next two years; and

(5) has had a recent diagnostic assessment~~, as provided in Minnesota Rules, part 9505.0372, subpart 1, by a mental health professional who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A,~~ that documents that intensive nonresidential

rehabilitative mental health services are medically necessary to ameliorate identified symptoms and functional impairments and to achieve individual transition goals.

Sec. 127. Minnesota Statutes 2018, section 256B.0947, subdivision 3a, is amended to read:

Subd. 3a. **Required service components.** ~~(a) Subject to federal approval, medical assistance covers all medically necessary intensive nonresidential rehabilitative mental health services and supports, as defined in this section, under a single daily rate per client. Services and supports must be delivered by an eligible provider under subdivision 5 to an eligible client under subdivision 3.~~

~~(b)~~ (a) Intensive nonresidential rehabilitative mental health services, supports, and ancillary activities covered by the single daily rate per client must include the following, as needed by the individual client:

(1) individual, family, and group psychotherapy;

(2) individual, family, and group skills training, as defined in section 256B.0943, subdivision 1, paragraph (t);

(3) crisis ~~assistance~~ planning as defined in section ~~245.4871, subdivision 9a, which includes recognition of factors precipitating a mental health crisis, identification of behaviors related to the crisis, and the development of a plan to address prevention, intervention, and follow-up strategies to be used in the lead-up to or onset of, and conclusion of, a mental health crisis; crisis assistance does not mean crisis response services or crisis intervention services provided in section 256B.0944~~ 256B.0943, subdivision 1, paragraph (c);

(4) medication management provided by a physician or an advanced practice registered nurse with certification in psychiatric and mental health care;

(5) mental health case management as provided in section 256B.0625, subdivision 20;

(6) medication education services ~~as defined in this section~~;

(7) care coordination by a client-specific lead worker assigned by and responsible to the treatment team;

(8) psychoeducation of and consultation and coordination with the client's biological, adoptive, or foster family and, in the case of a youth living independently, the client's immediate nonfamilial support network;

(9) clinical consultation to a client's employer or school or to other service agencies or to the courts to assist in managing the mental illness or co-occurring disorder and to develop client support systems;

(10) coordination with, or performance of, crisis intervention and stabilization services as defined in section 256B.0944;

(11) assessment of a client's treatment progress and effectiveness of services using standardized outcome measures published by the commissioner;

(12) transition services as defined in this section;

(13) integrated dual disorders treatment as defined in this section; and

(14) housing access support.

~~(c)~~ (b) The provider shall ensure and document the following by means of performing the required function or by contracting with a qualified person or entity:

(1) client access to crisis intervention services, as defined in section 256B.0944, and available 24 hours per day and seven days per week; and

~~(2) completion of an extended diagnostic assessment, as defined in Minnesota Rules, part 9505.0372, subpart 1, item C; and~~

~~(3)~~ (2) determination of the client's needed level of care using an instrument approved and periodically updated by the commissioner.

Sec. 128. Minnesota Statutes 2018, section 256B.0947, subdivision 5, is amended to read:

Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services must be provided by a provider entity as provided in subdivision 4.

(b) The treatment team for intensive nonresidential rehabilitative mental health services comprises both permanently employed core team members and client-specific team members as follows:

(1) ~~The core treatment team is an entity that operates under the direction of an independently licensed mental health professional, who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A, and that assumes comprehensive clinical responsibility for clients.~~ Based on professional qualifications and client needs, clinically qualified core team members are assigned on a rotating basis as the client's lead worker to coordinate a client's care. The core team must comprise at least four full-time equivalent direct care staff and must include~~, but is not limited to~~ at a minimum:

(i) ~~an independently licensed~~ a mental health professional~~, qualified under Minnesota Rules, part 9505.0371, subpart 5, item A,~~ who serves as team leader to provide administrative direction and ~~clinical~~ treatment supervision to the team;

(ii) an advanced-practice registered nurse with certification in psychiatric or mental health care or a board-certified child and adolescent psychiatrist, either of which must be credentialed to prescribe medications;

(iii) a licensed alcohol and drug counselor who is also trained in mental health interventions; and

(iv) a peer specialist ~~as defined in subdivision 2, paragraph (h)~~.

(2) The core team may also include any of the following:

(i) additional mental health professionals;

(ii) a vocational specialist;

(iii) an educational specialist;

(iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

(v) a mental health practitioner~~, as defined in~~ qualified according to section ~~245.4871, subdivision 26~~ 245I.16, subdivision 4;

(vi) a mental health manager, as defined in section 245.4871, subdivision 4; ~~and~~

(vii) a housing access specialist~~.~~; and

(viii) a clinical trainee qualified according to section 245I.16, subdivision 6.

(3) A treatment team may include, in addition to those in ~~clause~~ clauses (1) ~~or~~ and (2), ad hoc members not employed by the team who consult on a specific client and who must accept overall clinical direction from the treatment team for the duration of the client's placement with the treatment team and must be paid by the provider ~~agency at the rate for a typical session by that provider with that client or at a rate negotiated with the client-specific member~~ entity. Client-specific treatment team members may include:

(i) the mental health professional treating the client prior to placement with the treatment team;

(ii) the client's current substance abuse counselor, if applicable;

(iii) a lead member of the client's individualized education program team or school-based mental health provider, if applicable;

(iv) a representative from the client's health care home or primary care clinic, as needed to ensure integration of medical and behavioral health care;

(v) the client's probation officer or other juvenile justice representative, if applicable; and

(vi) the client's current vocational or employment counselor, if applicable.

(c) The ~~clinical~~ treatment supervisor shall be an active member of the treatment team and shall function as a practicing clinician at least on a part-time basis. The treatment team shall meet with the ~~clinical~~ treatment supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting must include client-specific case reviews and general treatment discussions among team members. Client-specific case reviews and planning must be documented in the individual client's treatment record.

(d) The staffing ratio must not exceed ten clients to one full-time equivalent treatment team position.

(e) The treatment team shall serve no more than 80 clients at any one time. Should local demand exceed the team's capacity, an additional team must be established rather than exceed this limit.

(f) Nonclinical staff shall have prompt access in person or by telephone to a mental health practitioner or mental health professional. The provider shall have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to assure the health and safety of clients.

(g) The intensive nonresidential rehabilitative mental health services provider shall participate in evaluation of the assertive community treatment for youth (Youth ACT) model as conducted by the commissioner, including the collection and reporting of data and the reporting of performance measures as specified by contract with the commissioner.

(h) A regional treatment team may serve multiple counties.

Sec. 129. Minnesota Statutes 2018, section 256B.0947, subdivision 6, is amended to read:

Subd. 6. **Service standards.** The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.

(a) The treatment team shall use team treatment, not an individual treatment model.

(b) Services must be available at times that meet client needs.

(c) The initial functional assessment must be completed within ten days of intake and updated at least every three months or prior to discharge from the service, whichever comes first.

(d) An individual treatment plan must be completed for each client, according to criteria specified in section ~~256B.0943, subdivision 6, paragraph (b), clause (2)~~ 256B.0671, subdivisions 5 and 6, and, additionally, must:

(1) be completed in consultation with the client's current therapist and key providers and provide for ongoing consultation with the client's current therapist to ensure therapeutic continuity and to facilitate the client's return to the community;

(2) if a need for substance use disorder treatment is indicated by validated assessment~~:~~,

~~(i)~~ identify goals, objectives, and strategies of substance use disorder treatment; develop a schedule for accomplishing treatment goals and objectives; and identify the individuals responsible for providing treatment services and supports; and

~~(ii) be reviewed at least once every 90 days and revised, if necessary;~~

~~(3) be signed by the clinical supervisor and by the client and, if the client is a minor, by the client's parent or other person authorized by statute to consent to mental health treatment and substance use disorder treatment for the client; and~~

~~(4)~~ (3) provide for the client's transition out of intensive nonresidential rehabilitative mental health services by defining the team's actions to assist the client and subsequent providers in the transition to less intensive or "stepped down" services.

(e) The treatment team shall actively and assertively engage the client's family members and significant others by establishing communication and collaboration with the family and significant others and educating the family and significant others about the client's mental illness, symptom management, and the family's role in treatment, unless the team knows or has reason to suspect that the client has suffered or faces a threat of suffering any physical or mental injury, abuse, or neglect from a family member or significant other.

(f) For a client age 18 or older, the treatment team may disclose to a family member, other relative, or a close personal friend of the client, or other person identified by the client, the protected health information directly relevant to such person's involvement with the client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the client is present, the treatment team shall obtain the client's agreement, provide the client with an opportunity to object, or reasonably infer from the circumstances, based on the exercise of professional judgment, that the client does not object. If the client is not present

or is unable, by incapacity or emergency circumstances, to agree or object, the treatment team may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the client and, if so, disclose only the protected health information that is directly relevant to the family member's, relative's, friend's, or client-identified person's involvement with the client's health care. The client may orally agree or object to the disclosure and may prohibit or restrict disclosure to specific individuals.

(g) The treatment team shall provide interventions to promote positive interpersonal relationships.

Sec. 130. Minnesota Statutes 2018, section 256B.0947, subdivision 7a, is amended to read:

Subd. 7a. **Noncovered services.** (a) The rate for intensive rehabilitative mental health services does not include medical assistance payment for services in clauses (1) to (7). Services not covered under this paragraph may be billed separately:

(1) inpatient psychiatric hospital treatment;

(2) partial hospitalization;

(3) children's mental health day treatment services;

(4) physician services outside of care provided by a psychiatrist serving as a member of the treatment team;

(5) room and board costs, as defined in section 256I.03, subdivision 6;

(6) home and community-based waiver services; and

(7) other mental health services identified in the child's individualized education program.

(b) The following services are not covered under this section and are not eligible for medical assistance payment while youth are receiving intensive rehabilitative mental health services:

(1) mental health residential treatment; and

(2) mental health behavioral aide services, as defined in section 256B.0943, subdivision 1, paragraph ~~(m)~~ (l).

Sec. 131. Minnesota Statutes 2018, section 256B.0949, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) The terms used in this section have the meanings given in this subdivision.

(b) "Agency" means the legal entity that is enrolled with Minnesota health care programs as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide EIDBI services and that has the legal responsibility to ensure that its employees or contractors carry out the responsibilities defined in this section. Agency includes a licensed individual professional who practices independently and acts as an agency.

(c) "Autism spectrum disorder or a related condition" or "ASD or a related condition" means either autism spectrum disorder (ASD) as defined in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or a condition that is found to be closely related to ASD, as identified under the current version of the DSM, and meets all of the following criteria:

(1) is severe and chronic;

(2) results in impairment of adaptive behavior and function similar to that of a person with ASD;

(3) requires treatment or services similar to those required for a person with ASD; and

(4) results in substantial functional limitations in three core developmental deficits of ASD: social interaction; nonverbal or social communication; and restrictive, repetitive behaviors or hyperreactivity or hyporeactivity to sensory input; and may include deficits or a high level of support in one or more of the following domains:

(i) self-regulation;

(ii) self-care;

(iii) behavioral challenges;

(iv) expressive communication;

(v) receptive communication;

(vi) cognitive functioning; or

(vii) safety.

(d) "Person" means a person under 21 years of age.

(e) "Clinical supervision" means the overall responsibility for the control and direction of EIDBI service delivery, including individual treatment planning, staff supervision, individual treatment plan progress monitoring, and treatment review for each person. Clinical supervision is provided by a qualified supervising professional (QSP) who takes full professional responsibility for the service provided by each supervisee.

(f) "Commissioner" means the commissioner of human services, unless otherwise specified.

(g) "Comprehensive multidisciplinary evaluation" or "CMDE" means a comprehensive evaluation of a person to determine medical necessity for EIDBI services based on the requirements in subdivision 5.

(h) "Department" means the Department of Human Services, unless otherwise specified.

(i) "Early intensive developmental and behavioral intervention benefit" or "EIDBI benefit" means a variety of individualized, intensive treatment modalities approved by the commissioner that are based in behavioral and developmental science consistent with best practices on effectiveness.

(j) "Generalizable goals" means results or gains that are observed during a variety of activities over time with different people, such as providers, family members, other adults, and people, and in different environments including, but not limited to, clinics, homes, schools, and the community.

(k) "Incident" means when any of the following occur:

(1) an illness, accident, or injury that requires first aid treatment;

(2) a bump or blow to the head; or

(3) an unusual or unexpected event that jeopardizes the safety of a person or staff, including a person leaving the agency unattended.

(l) "Individual treatment plan" or "ITP" means the person-centered, individualized written plan of care that integrates and coordinates person and family information from the CMDE for a person who meets medical necessity for the EIDBI benefit. An individual treatment plan must meet the standards in subdivision 6.

(m) "Legal representative" means the parent of a child who is under 18 years of age, a court-appointed guardian, or other representative with legal authority to make decisions about service for a person. For the purpose of this subdivision, "other representative with legal authority to make decisions" includes a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

(n) "Mental health professional" has the meaning given in section 245.4871, subdivision 27~~, clauses (1) to (6)~~.

(o) "Person-centered" means a service that both responds to the identified needs, interests, values, preferences, and desired outcomes of the person or the person's legal representative

and respects the person's history, dignity, and cultural background and allows inclusion and participation in the person's community.

(p) "Qualified EIDBI provider" means a person who is a QSP or a level I, level II, or level III treatment provider.

Sec. 132. Minnesota Statutes 2018, section 256B.0949, subdivision 4, is amended to read:

Subd. 4. **Diagnosis.** (a) A diagnosis of ASD or a related condition must:

(1) be based upon current DSM criteria including direct observations of the person and information from the person's legal representative or primary caregivers;

(2) be completed by either (i) a licensed physician or advanced practice registered nurse or (ii) a mental health professional; and

(3) meet the requirements of ~~Minnesota Rules, part 9505.0372, subpart 1, items B and C~~ section 256B.071, subdivisions 2 and 3.

(b) Additional assessment information may be considered to complete a diagnostic assessment including specialized tests administered through special education evaluations and licensed school personnel, and from professionals licensed in the fields of medicine, speech and language, psychology, occupational therapy, and physical therapy. A diagnostic assessment may include treatment recommendations.

Sec. 133. Minnesota Statutes 2018, section 256B.0949, subdivision 5a, is amended to read:

Subd. 5a. **Comprehensive multidisciplinary evaluation provider qualification.** A CMDE provider must:

(1) be a licensed physician, advanced practice registered nurse, a mental health professional, or a ~~mental health practitioner who meets the requirements of a~~ clinical trainee ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item C~~ described under section 245I.16, subdivision 6;

(2) have at least 2,000 hours of clinical experience in the evaluation and treatment of people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in the following content areas: ASD or a related condition diagnosis, ASD or a related condition treatment strategies, and child development; and

(3) be able to diagnose, evaluate, or provide treatment within the provider's scope of practice and professional license.

Sec. 134. **DIRECTION TO COMMISSIONER; SINGLE COMPREHENSIVE LICENSE STRUCTURE.**

The commissioner of human services, in consultation with stakeholders including but not limited to counties, tribes, managed care organizations, provider organizations, advocacy groups, and individuals and families served, shall develop recommendations to provide a single comprehensive license structure for mental health service programs, including community mental health centers according to Minnesota Rules, part 9520.0750, intensive residential treatment services, assertive community treatment, adult rehabilitative mental health services, children's therapeutic services and supports, intensive rehabilitative mental health services, intensive treatment in foster care, and children's residential treatment programs currently approved under Minnesota Rules, chapter 2960. The recommendations must prioritize program integrity, the welfare of individuals and families served, improved integration of mental health and substance use disorder services, and the reduction of administrative burden on providers.

Sec. 135. **REPEALER.**

(a) Minnesota Statutes 2018, sections 245.462, subdivision 4a; 256B.0615, subdivisions 2, 4, and 5; 256B.0616, subdivisions 2, 4, and 5; 256B.0624, subdivision 10; 256B.0943, subdivision 10; 256B.0944, subdivision 10; 256B.0946, subdivision 5; and 256B.0947, subdivision 9, are repealed.

(b) Minnesota Rules, parts 9505.0370; 9505.0371; 9505.0372; 9520.0010; 9520.0020; 9520.0030; 9520.0040; 9520.0050; 9520.0060; 9520.0070; 9520.0080; 9520.0090; 9520.0100; 9520.0110; 9520.0120; 9520.0130; 9520.0140; 9520.0150; 9520.0160; 9520.0170; 9520.0180; 9520.0190; 9520.0200; 9520.0210; and 9520.0230, are repealed.

## ARTICLE 8
## HEALTH CARE

Section 1. Minnesota Statutes 2018, section 13.69, subdivision 1, is amended to read:

Subdivision 1. **Classifications.** (a) The following government data of the Department of Public Safety are private data:

(1) medical data on driving instructors, licensed drivers, and applicants for parking certificates and special license plates issued to physically disabled persons;

(2) other data on holders of a disability certificate under section 169.345, except that (i) data that are not medical data may be released to law enforcement agencies, and (ii) data

necessary for enforcement of sections 169.345 and 169.346 may be released to parking enforcement employees or parking enforcement agents of statutory or home rule charter cities and towns;

(3) Social Security numbers in driver's license and motor vehicle registration records, except that Social Security numbers must be provided to the Department of Revenue for purposes of tax administration, the Department of Labor and Industry for purposes of workers' compensation administration and enforcement, the judicial branch for purposes of debt collection, and the Department of Natural Resources for purposes of license application administration, and except that the last four digits of the Social Security number must be provided to the Department of Human Services for purposes of recovery of Minnesota health care program benefits paid; and

(4) data on persons listed as standby or temporary custodians under section 171.07, subdivision 11, except that the data must be released to:

(i) law enforcement agencies for the purpose of verifying that an individual is a designated caregiver; or

(ii) law enforcement agencies who state that the license holder is unable to communicate at that time and that the information is necessary for notifying the designated caregiver of the need to care for a child of the license holder.

The department may release the Social Security number only as provided in clause (3) and must not sell or otherwise provide individual Social Security numbers or lists of Social Security numbers for any other purpose.

(b) The following government data of the Department of Public Safety are confidential data: data concerning an individual's driving ability when that data is received from a member of the individual's family.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 2. Minnesota Statutes 2018, section 16A.724, subdivision 2, is amended to read:

Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, effective for the biennium beginning July 1, 2007, the commissioner of management and budget shall transfer the excess funds from the health care access fund to the general fund on June 30 of each year, provided that the amount transferred in fiscal year 2016 shall not exceed $48,000,000, the amount in fiscal year 2017 shall not exceed $122,000,000, and the amount in any fiscal biennium thereafter shall not exceed $244,000,000. The purpose of this transfer is to meet

the rate increase required under ~~Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6~~ section 256B.0625, subdivision 67.

(b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if necessary, the commissioner shall reduce these transfers from the health care access fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer sufficient funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

Sec. 3. Minnesota Statutes 2018, section 62A.671, subdivision 6, is amended to read:

Subd. 6. **Licensed health care provider.** "Licensed health care provider" means a health care provider who is:

(1) licensed under chapter 147, 147A, 148, 148B, 148E, 148F, 150A, or 153; a mental health professional as defined under section 245.462, subdivision 18, or 245.4871, subdivision 27; a community health worker meeting the criteria specified in section 256B.0625, subdivision 49, paragraph (a); or vendor of medical care defined in section 256B.02, subdivision 7; and

(2) authorized within their respective scope of practice to provide the particular service with no supervision or under general supervision.

Sec. 4. Minnesota Statutes 2018, section 62Q.184, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms in this subdivision have the meanings given them.

(b) "Clinical practice guideline" means a systematically developed statement to assist health care providers and enrollees in making decisions about appropriate health care services for specific clinical circumstances and conditions developed independently of a health plan company, pharmaceutical manufacturer, or any entity with a conflict of interest. A clinical practice guideline also includes a preferred drug list developed in accordance with section 256B.0625.

(c) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and clinical practice guidelines used by a health plan company to determine the medical necessity and appropriateness of health care services.

(d) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, but ~~does not include a managed care organization or~~ also includes a county-based purchasing

plan participating in a public program under chapter 256B or 256L~~, or~~ and an integrated health partnership under section 256B.0755.

(e) "Step therapy protocol" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition, including self-administered and physician-administered drugs, are medically appropriate for a particular enrollee and are covered under a health plan.

(f) "Step therapy override" means that the step therapy protocol is overridden in favor of coverage of the selected prescription drug of the prescribing health care provider because at least one of the conditions of subdivision 3, paragraph (a), exists.

Sec. 5. Minnesota Statutes 2018, section 62Q.184, subdivision 3, is amended to read:

Subd. 3. **Step therapy override process; transparency.** (a) When coverage of a prescription drug for the treatment of a medical condition is restricted for use by a health plan company through the use of a step therapy protocol, enrollees and prescribing health care providers shall have access to a clear, readily accessible, and convenient process to request a step therapy override. The process shall be made easily accessible on the health plan company's website. A health plan company may use its existing medical exceptions process to satisfy this requirement. A health plan company shall grant an override to the step therapy protocol if at least one of the following conditions exist:

(1) the prescription drug required under the step therapy protocol is contraindicated pursuant to the pharmaceutical manufacturer's prescribing information for the drug or, due to a documented adverse event with a previous use or a documented medical condition, including a comorbid condition, is likely to do any of the following:

(i) cause an adverse reaction to the enrollee;

(ii) decrease the ability of the enrollee to achieve or maintain reasonable functional ability in performing daily activities; or

(iii) cause physical or mental harm to the enrollee;

(2) the enrollee has had a trial of the required prescription drug covered by their current or previous health plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and was adherent during such trial for a period of time sufficient to allow for a positive treatment outcome, and the prescription drug was discontinued by the enrollee's health care provider due to lack of effectiveness, or an adverse event. This clause does not prohibit a health plan company from requiring an enrollee to try another drug in the same pharmacologic class or with the same mechanism of action if

that therapy sequence is supported by the evidence-based and peer-reviewed clinical practice guideline, Food and Drug Administration label, or pharmaceutical manufacturer's prescribing information; or

(3) the enrollee is currently receiving a positive therapeutic outcome on a prescription drug for the medical condition under consideration if, while on their current health plan or the immediately preceding health plan, the enrollee received coverage for the prescription drug and the enrollee's prescribing health care provider gives documentation to the health plan company that the change in prescription drug required by the step therapy protocol is expected to be ineffective or cause harm to the enrollee based on the known characteristics of the specific enrollee and the known characteristics of the required prescription drug.

(b) Upon granting a step therapy override, a health plan company shall authorize coverage for the prescription drug if the prescription drug is a covered prescription drug under the enrollee's health plan.

(c) The enrollee, or the prescribing health care provider if designated by the enrollee, may appeal the denial of a step therapy override by a health plan company using the complaint procedure under sections 62Q.68 to 62Q.73 or 256.045.

(d) In a denial of an override request and any subsequent appeal, a health plan company's decision must specifically state why the step therapy override request did not meet the condition under paragraph (a) cited by the prescribing health care provider in requesting the step therapy override and information regarding the procedure to request external review of the denial pursuant to section 62Q.73. A denial of a request for a step therapy override that is upheld on appeal is a final adverse determination for purposes of section 62Q.73 and is eligible for a request for external review by an enrollee pursuant to section 62Q.73.

(e) A health plan company shall respond to a step therapy override request or an appeal within five days of receipt of a complete request. In cases where exigent circumstances exist, a health plan company shall respond within 72 hours of receipt of a complete request. If a health plan company does not send a response to the enrollee or prescribing health care provider if designated by the enrollee within the time allotted, the override request or appeal is granted and binding on the health plan company.

(f) Step therapy override requests must be accessible to and submitted by health care providers, and accepted by group purchasers electronically through secure electronic transmission, as described under section 62J.497, subdivision 5.

(g) Nothing in this section prohibits a health plan company from:

(1) requesting relevant documentation from an enrollee's medical record in support of a step therapy override request; or

(2) requiring an enrollee to try a generic equivalent drug pursuant to section 151.21, or a biosimilar, as defined under United States Code, chapter 42, section 262(i)(2), prior to providing coverage for the equivalent branded prescription drug.

(h) This section shall not be construed to allow the use of a pharmaceutical sample for the primary purpose of meeting the requirements for a step therapy override.

Sec. 6. Minnesota Statutes 2018, section 245A.02, subdivision 5a, is amended to read:

Subd. 5a. **Controlling individual.** (a) "Controlling individual" means an owner of a program or service provider licensed under this chapter and the following individuals, if applicable:

(1) each officer of the organization, including the chief executive officer and chief financial officer;

(2) the individual designated as the authorized agent under section 245A.04, subdivision 1, paragraph (b);

(3) the individual designated as the compliance officer under section 256B.04, subdivision 21, paragraph ~~(b)~~ (g); and

(4) each managerial official whose responsibilities include the direction of the management or policies of a program.

(b) Controlling individual does not include:

(1) a bank, savings bank, trust company, savings association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity operates a program directly or through a subsidiary;

(2) an individual who is a state or federal official, or state or federal employee, or a member or employee of the governing body of a political subdivision of the state or federal government that operates one or more programs, unless the individual is also an officer, owner, or managerial official of the program, receives remuneration from the program, or owns any of the beneficial interests not excluded in this subdivision;

(3) an individual who owns less than five percent of the outstanding common shares of a corporation:

(i) whose securities are exempt under section 80A.45, clause (6); or

(ii) whose transactions are exempt under section 80A.46, clause (2);

(4) an individual who is a member of an organization exempt from taxation under section 290.05, unless the individual is also an officer, owner, or managerial official of the program or owns any of the beneficial interests not excluded in this subdivision. This clause does not exclude from the definition of controlling individual an organization that is exempt from taxation; or

(5) an employee stock ownership plan trust, or a participant or board member of an employee stock ownership plan, unless the participant or board member is a controlling individual according to paragraph (a).

(c) For purposes of this subdivision, "managerial official" means an individual who has the decision-making authority related to the operation of the program, and the responsibility for the ongoing management of or direction of the policies, services, or employees of the program. A site director who has no ownership interest in the program is not considered to be a managerial official for purposes of this definition.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 7. Minnesota Statutes 2018, section 245D.081, subdivision 3, is amended to read:

Subd. 3. **Program management and oversight.** (a) The license holder must designate a managerial staff person or persons to provide program management and oversight of the services provided by the license holder. The designated manager is responsible for the following:

(1) maintaining a current understanding of the licensing requirements sufficient to ensure compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph (e), and when applicable, as identified in section 256B.04, subdivision 21, paragraph ~~(b)~~ (g);

(2) ensuring the duties of the designated coordinator are fulfilled according to the requirements in subdivision 2;

(3) ensuring the program implements corrective action identified as necessary by the program following review of incident and emergency reports according to the requirements in section 245D.11, subdivision 2, clause (7). An internal review of incident reports of alleged or suspected maltreatment must be conducted according to the requirements in section 245A.65, subdivision 1, paragraph (b);

(4) evaluation of satisfaction of persons served by the program, the person's legal representative, if any, and the case manager, with the service delivery and progress ~~towards~~ toward accomplishing outcomes identified in sections 245D.07 and 245D.071, and ensuring and protecting each person's rights as identified in section 245D.04;

(5) ensuring staff competency requirements are met according to the requirements in section 245D.09, subdivision 3, and ensuring staff orientation and training is provided according to the requirements in section 245D.09, subdivisions 4, 4a, and 5;

(6) ensuring corrective action is taken when ordered by the commissioner and that the terms and conditions of the license and any variances are met; and

(7) evaluating the information identified in clauses (1) to (6) to develop, document, and implement ongoing program improvements.

(b) The designated manager must be competent to perform the duties as required and must minimally meet the education and training requirements identified in subdivision 2, paragraph (b), and have a minimum of three years of supervisory level experience in a program providing direct support services to persons with disabilities or persons age 65 and older.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 8. Minnesota Statutes 2018, section 256.962, subdivision 5, is amended to read:

Subd. 5. **Incentive program.** Beginning January 1, 2008, the commissioner shall establish an incentive program for organizations and licensed insurance producers under chapter 60K that directly identify and assist potential enrollees in filling out and submitting an application. For each applicant who is successfully enrolled in MinnesotaCare or medical assistance, the commissioner, within the available appropriation, shall pay the organization or licensed insurance producer a ~~$25~~ $70 application assistance bonus. The organization or licensed insurance producer may provide an applicant a gift certificate or other incentive upon enrollment.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 9. Minnesota Statutes 2018, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according to the following:

(1) critical access hospitals as defined by Medicare shall be paid using a cost-based methodology;

(2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology under subdivision 25;

(3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation distinct parts as defined by Medicare shall be paid according to the methodology under subdivision 12; and

(4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

(b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not be rebased, except that a Minnesota long-term hospital shall be rebased effective January 1, 2011, based on its most recent Medicare cost report ending on or before September 1, 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For rate setting periods after November 1, 2014, in which the base years are updated, a Minnesota long-term hospital's base year shall remain within the same period as other hospitals.

(c) Effective for discharges occurring on and after November 1, 2014, payment rates for hospital inpatient services provided by hospitals located in Minnesota or the local trade area, except for the hospitals paid under the methodologies described in paragraph (a), clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a manner similar to Medicare. The base year for the rates effective November 1, 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring that the total aggregate payments under the rebased system are equal to the total aggregate payments that were made for the same number and types of services in the base year. Separate budget neutrality calculations shall be determined for payments made to critical access hospitals and payments made to hospitals paid under the DRG system. Only the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during the entire base period shall be incorporated into the budget neutrality calculation.

(d) For discharges occurring on or after November 1, 2014, through the next rebasing that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph (a), clause (4), shall include adjustments to the projected rates that result in no greater than a five percent increase or decrease from the base year payments for any hospital. Any adjustments to the rates made by the commissioner under this paragraph and paragraph (e) shall maintain budget neutrality as described in paragraph (c).

(e) For discharges occurring on or after November 1, 2014, ~~through the next two rebasing periods~~ the commissioner may make additional adjustments to the rebased rates, and when evaluating whether additional adjustments should be made, the commissioner shall consider the impact of the rates on the following:

(1) pediatric services;

(2) behavioral health services;

(3) trauma services as defined by the National Uniform Billing Committee;

(4) transplant services;

(5) obstetric services, newborn services, and behavioral health services provided by hospitals outside the seven-county metropolitan area;

(6) outlier admissions;

(7) low-volume providers; and

(8) services provided by small rural hospitals that are not critical access hospitals.

(f) Hospital payment rates established under paragraph (c) must incorporate the following:

(1) for hospitals paid under the DRG methodology, the base year payment rate per admission is standardized by the applicable Medicare wage index and adjusted by the hospital's disproportionate population adjustment;

(2) for critical access hospitals, payment rates for discharges between November 1, 2014, and June 30, 2015, shall be set to the same rate of payment that applied for discharges on October 31, 2014;

(3) the cost and charge data used to establish hospital payment rates must only reflect inpatient services covered by medical assistance; and

(4) in determining hospital payment rates for discharges occurring on or after the rate year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per discharge shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years. In determining hospital payment rates for discharges in subsequent base years, the per discharge rates shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years.

(g) The commissioner shall validate the rates effective November 1, 2014, by applying the rates established under paragraph (c), and any adjustments made to the rates under

paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the total aggregate payments for the same number and types of services under the rebased rates are equal to the total aggregate payments made during calendar year 2013.

(h) Effective for discharges occurring on or after July 1, 2017, and every two years thereafter, payment rates under this section shall be rebased to reflect only those changes in hospital costs between the existing base year and the next base year. Changes in costs between base years shall be measured using the lower of the hospital cost index defined in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per claim. The commissioner shall establish the base year for each rebasing period considering the most recent year for which filed Medicare cost reports are available. The estimated change in the average payment per hospital discharge resulting from a scheduled rebasing must be calculated and made available to the legislature by January 15 of each year in which rebasing is scheduled to occur, and must include by hospital the differential in payment rates compared to the individual hospital's costs.

(i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates for critical access hospitals located in Minnesota or the local trade area shall be determined using a new cost-based methodology. The commissioner shall establish within the methodology tiers of payment designed to promote efficiency and cost-effectiveness. Payment rates for hospitals under this paragraph shall be set at a level that does not exceed the total cost for critical access hospitals as reflected in base year cost reports. Until the next rebasing that occurs, the new methodology shall result in no greater than a five percent decrease from the base year payments for any hospital, except a hospital that had payments that were greater than 100 percent of the hospital's costs in the base year shall have their rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and after July 1, 2016, covered under this paragraph shall be increased by the inflation factor in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the following criteria:

(1) hospitals that had payments at or below 80 percent of their costs in the base year shall have a rate set that equals 85 percent of their base year costs;

(2) hospitals that had payments that were above 80 percent, up to and including 90 percent of their costs in the base year shall have a rate set that equals 95 percent of their base year costs; and

(3) hospitals that had payments that were above 90 percent of their costs in the base year shall have a rate set that equals 100 percent of their base year costs.

(j) The commissioner may refine the payment tiers and criteria for critical access hospitals to coincide with the next rebasing under paragraph (h). The factors used to develop the new methodology may include, but are not limited to:

(1) the ratio between the hospital's costs for treating medical assistance patients and the hospital's charges to the medical assistance program;

(2) the ratio between the hospital's costs for treating medical assistance patients and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(3) the ratio between the hospital's charges to the medical assistance program and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

(5) the proportion of that hospital's costs that are administrative and trends in administrative costs; and

(6) geographic location.

Sec. 10. Minnesota Statutes 2018, section 256.969, subdivision 3a, is amended to read:

Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third-party and recipient liability, for discharges occurring during the rate year shall not exceed, ~~in aggregate~~ on a per claim basis, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. Services that have rates established under subdivision 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best

Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates 30 days prior to implementation. The rate setting data must reflect the admissions data used to establish relative values. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

(b) For fee-for-service admissions occurring on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for inpatient services is reduced by .5 percent from the current statutory rates.

(c) In addition to the reduction in paragraph (b), the total payment for fee-for-service admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph.

(d) In addition to the reduction in paragraphs (b) and (c), the total payment for fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 6.0 percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2006, to reflect this reduction.

(e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 3.46 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

(f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2009, through June 30, 2011, to reflect this reduction.

(g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.79 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2011, to reflect this reduction.

(h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total payment for fee-for-service admissions occurring on or after July 1, 2009, made to hospitals for inpatient services before third-party liability and spenddown, is reduced one percent from the current statutory rates. Facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

(i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total payment for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.96 percent from the current statutory rates. Facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2011, to reflect this reduction.

(j) Effective for discharges on and after November 1, 2014, from hospitals paid under subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this subdivision must be incorporated into the rebased rates established under subdivision 2b, paragraph (c), and must not be applied to each claim.

(k) Effective for discharges on and after July 1, 2015, from hospitals paid under subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision must be incorporated into the rates and must not be applied to each claim.

(l) Effective for discharges on and after July 1, 2017, from hospitals paid under subdivision 2b, paragraph (a), clause (2), the rate adjustments in this subdivision must be incorporated into the rates and must not be applied to each claim.

Sec. 11. Minnesota Statutes 2018, section 256.969, subdivision 9, is amended to read:

Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.

(b) Certified public expenditures made by Hennepin County Medical Center shall be considered Medicaid disproportionate share hospital payments. Hennepin County and Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning July 1, 2005, or another date specified by the commissioner, that may qualify for reimbursement under federal law. Based on these reports, the commissioner shall apply for federal matching funds.

(c) Upon federal approval of the related state plan amendment, paragraph (b) is effective retroactively from July 1, 2005, or the earliest effective date approved by the Centers for Medicare and Medicaid Services.

(d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid in accordance with a new methodology using 2012 as the base year. Annual payments made under this paragraph shall equal the total amount of payments made for 2012. A licensed children's hospital shall receive only a single DSH factor for children's hospitals. Other DSH factors may be combined to arrive at a single factor for each hospital that is eligible for DSH payments. The new methodology shall make payments only to hospitals located in Minnesota and include the following factors:

(1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000 fee-for-service discharges in the base year shall receive a factor of 0.7880;

(2) a hospital that has in effect for the initial rate year a contract with the commissioner to provide extended psychiatric inpatient services under section 256.9693 shall receive a factor of 0.0160;

(3) a hospital that has received payment from the fee-for-service program for at least 20 transplant services in the base year shall receive a factor of 0.0435;

(4) a hospital that has a medical assistance utilization rate in the base year between 20 percent up to one standard deviation above the statewide mean utilization rate shall receive a factor of 0.0468;

(5) a hospital that has a medical assistance utilization rate in the base year that is at least one standard deviation above the statewide mean utilization rate but is less than three standard deviations above the mean shall receive a factor of 0.2300; and

(6) a hospital that has a medical assistance utilization rate in the base year that is at least ~~three~~ two and one-half standard deviations above the statewide mean utilization rate shall receive a factor of 0.3711.

(e) Any payments or portion of payments made to a hospital under this subdivision that are subsequently returned to the commissioner because the payments are found to exceed the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the number of fee-for-service discharges, to other DSH-eligible non-children's hospitals that have a medical assistance utilization rate that is at least one standard deviation above the mean.

(f) An additional payment adjustment shall be established by the commissioner under this subdivision for a hospital that provides high levels of administering high-cost drugs to enrollees in fee-for-service medical assistance. The commissioner shall consider factors

including fee-for-service medical assistance utilization rates and payments made for drugs purchased through the 340B drug purchasing program and administered to fee-for-service enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate share hospital limit, the commissioner shall make a payment to the hospital that equals the nonfederal share of the amount that exceeds the limit. The total nonfederal share of the amount of the payment adjustment under this paragraph shall not exceed $1,500,000.

**EFFECTIVE DATE.** This section is effective July 1, 2019, except paragraph (f) is effective for discharges on or after April 1, 2019.

Sec. 12. Minnesota Statutes 2018, section 256.969, subdivision 17, is amended to read:

Subd. 17. **Out-of-state hospitals in local trade areas.** Out-of-state hospitals that are located within a Minnesota local trade area and that have ~~more than 20~~ admissions in the base year or years shall have rates established using the same procedures and methods that apply to Minnesota hospitals. For this subdivision and subdivision 18, local trade area means a county contiguous to Minnesota and located in a metropolitan statistical area as determined by Medicare for October 1 prior to the most current rebased rate year. Hospitals that are not required by law to file information in a format necessary to establish rates shall have rates established based on the commissioner's estimates of the information. Relative values of the diagnostic categories shall not be redetermined under this subdivision until required by statute. Hospitals affected by this subdivision shall then be included in determining relative values. However, hospitals that have rates established based upon the commissioner's estimates of information shall not be included in determining relative values. This subdivision is effective for hospital fiscal years beginning on or after July 1, 1988. A hospital shall provide the information necessary to establish rates under this subdivision at least 90 days before the start of the hospital's fiscal year.

Sec. 13. Minnesota Statutes 2018, section 256.969, subdivision 19, is amended to read:

Subd. 19. **Metabolic disorder testing of medical assistance recipients.** Medical assistance inpatient payment rates must include the cost incurred by hospitals to pay the Department of Health for metabolic disorder testing of newborns who are medical assistance recipients, if the cost is not recognized by another payment source. This payment increase remains in effect until the increase is fully recognized in the base year cost under subdivision 2b.

Sec. 14. Minnesota Statutes 2018, section 256B.04, subdivision 14, is amended to read:

Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C, to provide items under the medical assistance program including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies; ~~and~~

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

(viii) electronic diagnostic, therapeutic and life-support systems; and

(ix) allergen-reducing products as described in section 256B.0625, subdivision 66, paragraph (c);

(5) nonemergency medical transportation level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursements; and

(6) drugs.

(b) Rate changes and recipient cost-sharing under this chapter and chapter 256L do not affect contract payments under this subdivision unless specifically identified.

(c) The commissioner may not utilize volume purchase through competitive bidding and negotiation for special transportation services under the provisions of chapter 16C.

Sec. 15. Minnesota Statutes 2018, section 256B.04, subdivision 21, is amended to read:

Subd. 21. **Provider enrollment.** (a) The commissioner shall enroll providers and conduct screening activities as required by Code of Federal Regulations, title 42, section 455, subpart E. A provider providing services from multiple locations must enroll each location separately. The commissioner may deny a provider's incomplete application if a provider fails to respond to the commissioner's request for additional information within 60 days of the request. The commissioner must conduct a background study under chapter 245C, including a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5), for a provider described in this paragraph. The background study requirement may be satisfied if the commissioner conducted a fingerprint-based background study on the provider that includes a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5).

(b) The commissioner shall revalidate each: (1) provider under this subdivision at least once every five years; and (2) personal care assistance agency under this subdivision once every three years.

(c) The commissioner shall conduct revalidation as follows:

(1) provide 30-day notice of the revalidation due date including instructions for revalidation and a list of materials the provider must submit;

(2) if a provider fails to submit all required materials by the due date, notify the provider of the deficiency within 30 days after the due date and allow the provider an additional 30 days from the notification date to comply; and

(3) if a provider fails to remedy a deficiency within the 30-day time period, give 60-day notice of termination and immediately suspend the provider's ability to bill. The provider does not have the right to appeal suspension of ability to bill.

(d) If a provider fails to comply with any individual provider requirement or condition of participation, the commissioner may suspend the provider's ability to bill until the provider comes into compliance. The commissioner's decision to suspend the provider is not subject to an administrative appeal.

(e) All correspondence and notifications, including notifications of termination and other actions, must be delivered electronically to a provider's MN-ITS mailbox. For a provider that does not have a MN-ITS account and mailbox, notice must be sent by first-class mail. This paragraph does not apply to correspondences and notifications related to background studies.

(f) If the commissioner or the Centers for Medicare and Medicaid Services determines that a provider is designated "high-risk," the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.

~~(b)~~ (g) An enrolled provider that is also licensed by the commissioner under chapter 245A, or is licensed as a home care provider by the Department of Health under chapter 144A and has a home and community-based services designation on the home care license under section 144A.484, must designate an individual as the entity's compliance officer. The compliance officer must:

(1) develop policies and procedures to assure adherence to medical assistance laws and regulations and to prevent inappropriate claims submissions;

(2) train the employees of the provider entity, and any agents or subcontractors of the provider entity including billers, on the policies and procedures under clause (1);

(3) respond to allegations of improper conduct related to the provision or billing of medical assistance services, and implement action to remediate any resulting problems;

(4) use evaluation techniques to monitor compliance with medical assistance laws and regulations;

(5) promptly report to the commissioner any identified violations of medical assistance laws or regulations; and

(6) within 60 days of discovery by the provider of a medical assistance reimbursement overpayment, report the overpayment to the commissioner and make arrangements with the commissioner for the commissioner's recovery of the overpayment.

The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.

~~(c)~~ (h) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure to maintain documentation or provide access to documentation on more than one occasion.

Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.

~~(d)~~ (i) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state.

~~(e)~~ (j) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14. The commissioner's designations are not subject to administrative appeal.

~~(f)~~ (k) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

~~(g)~~ (l)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers meeting the durable medical equipment provider and supplier definition in clause (3), operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the obligee, and must be submitted in a form approved by the commissioner. For purposes of this clause, the following medical suppliers are not required to obtain a surety bond: a federally qualified health center, a home health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

(2) At the time of initial enrollment or reenrollment, durable medical equipment providers and suppliers defined in clause (3) must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If a revalidating provider's

Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must allow for recovery of costs and fees in pursuing a claim on the bond.

(3) "Durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rental to the general public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rental.

~~(h)~~ (m) The Department of Human Services may require a provider to purchase a surety bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the department determines there is significant evidence of or potential for fraud and abuse by the provider, or (3) the provider or category of providers is designated high-risk pursuant to paragraph ~~(a)~~ (f) and as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an amount of $100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The surety bond must name the Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond. This paragraph does not apply if the provider currently maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 16. Minnesota Statutes 2018, section 256B.04, subdivision 22, is amended to read:

Subd. 22. **Application fee.** (a) The commissioner must collect and retain federally required nonrefundable application fees to pay for provider screening activities in accordance with Code of Federal Regulations, title 42, section 455, subpart E. The enrollment application must be made under the procedures specified by the commissioner, in the form specified by the commissioner, and accompanied by an application fee described in paragraph (b), or a request for a hardship exception as described in the specified procedures. Application fees must be deposited in the provider screening account in the special revenue fund. Amounts in the provider screening account are appropriated to the commissioner for costs associated with the provider screening activities required in Code of Federal Regulations, title 42, section 455, subpart E. ~~The commissioner shall conduct screening activities as required by Code of Federal Regulations, title 42, section 455, subpart E, and as otherwise provided by law, to include database checks, unannounced pre- and postenrollment site visits, fingerprinting, and criminal background studies. The commissioner must revalidate all providers under this subdivision at least once every five years.~~

(b) The application fee under this subdivision is $532 for the calendar year 2013. For calendar year 2014 and subsequent years, the fee:

(1) is adjusted by the percentage change to the Consumer Price Index for all urban consumers, United States city average, for the 12-month period ending with June of the previous year. The resulting fee must be announced in the Federal Register;

(2) is effective from January 1 to December 31 of a calendar year;

(3) is required on the submission of an initial application, an application to establish a new practice location, an application for reenrollment when the provider is not enrolled at the time of application of reenrollment, or at revalidation when required by federal regulation; and

(4) must be in the amount in effect for the calendar year during which the application for enrollment, new practice location, or reenrollment is being submitted.

(c) The application fee under this subdivision cannot be charged to:

(1) providers who are enrolled in Medicare or who provide documentation of payment of the fee to, and enrollment with, another state, unless the commissioner is required to rescreen the provider;

(2) providers who are enrolled but are required to submit new applications for purposes of reenrollment;

(3) a provider who enrolls as an individual; and

(4) group practices and clinics that bill on behalf of individually enrolled providers within the practice who have reassigned their billing privileges to the group practice or clinic.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 17. Minnesota Statutes 2018, section 256B.055, subdivision 2, is amended to read:

Subd. 2. **Subsidized foster children.** Medical assistance may be paid for a child eligible for or receiving foster care maintenance payments under Title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676, and for a child who is not eligible for Title IV-E of the Social Security Act but who is determined eligible for foster care or kinship assistance under chapter 256N.

**EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 18. Minnesota Statutes 2018, section 256B.056, subdivision 3, is amended to read:

Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical assistance, a person must not individually own more than $3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than $6,000 in assets, plus $200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the Supplemental Security Income program for aged, blind, and disabled persons, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered;

(3) motor vehicles are excluded to the same extent excluded by the Supplemental Security Income program;

(4) assets designated as burial expenses are excluded to the same extent excluded by the Supplemental Security Income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses;

(5) for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

(6) ~~when a person enrolled in medical assistance under section 256B.057, subdivision 9, is age 65 or older and has been enrolled during each of the 24 consecutive months before the person's 65th birthday, the assets owned by the person and the person's spouse must be~~

~~disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when determining eligibility for medical assistance under section 256B.055, subdivision 7.~~ a designated employment incentives asset account is disregarded when determining eligibility for medical assistance for a person age 65 years or older under section 256B.055, subdivision 7. An employment incentives asset account must only be designated by a person who has been enrolled in medical assistance under section 256B.057, subdivision 9, for a 24-consecutive-month period. A designated employment incentives asset account contains qualified assets owned by the person and the person's spouse in the last month of enrollment in medical assistance under section 256B.057, subdivision 9. Qualified assets include retirement and pension accounts, medical expense accounts, and up to $17,000 of the person's other nonexcluded assets. An employment incentives asset account is no longer designated when a person loses medical assistance eligibility for a calendar month or more before turning age 65. A person who loses medical assistance eligibility before age 65 can establish a new designated employment incentives asset account by establishing a new 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. The income of a spouse of a person enrolled in medical assistance under section 256B.057, subdivision 9, during each of the 24 consecutive months before the person's 65th birthday must be disregarded when determining eligibility for medical assistance under section 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions in section 256B.059; and

(7) effective July 1, 2009, certain assets owned by American Indians are excluded as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(b) No asset limit shall apply to persons eligible under section 256B.055, subdivision 15.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 19. Minnesota Statutes 2018, section 256B.056, subdivision 5c, is amended to read:

Subd. 5c. **Excess income standard.** (a) The excess income standard for parents and caretaker relatives, pregnant women, infants, and children ages two through 20 is the standard specified in subdivision 4, paragraph (b).

(b) The excess income standard for a person whose eligibility is based on blindness, disability, or age of 65 or more years shall equal:

(1) 81 percent of the federal poverty guidelines; and

(2) 83 percent of the federal poverty guidelines, effective July 1, 2021.

Sec. 20. Minnesota Statutes 2018, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine in the same manner as if the service or consultation was delivered in person. Coverage is limited to three telemedicine services per enrollee per calendar week, except as provided in paragraph (f). Telemedicine services shall be paid at the full allowable rate.

(b) The commissioner shall establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service via telemedicine. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide via telemedicine;

(2) has written policies and procedures specific to telemedicine services that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the telemedicine service is rendered;

(4) has established protocols addressing how and when to discontinue telemedicine services; and

(5) has an established quality assurance process related to telemedicine services.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service provided by telemedicine to a medical assistance enrollee. Health care service records for services provided by telemedicine must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service provided by telemedicine;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) the licensed health care provider's basis for determining that telemedicine is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission of the telemedicine service and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's telemedicine consultation with another physician, the written opinion from the consulting physician providing the telemedicine consultation; and

(7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) For purposes of this subdivision, unless otherwise covered under this chapter, "telemedicine" is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

(e) For purposes of this section, "licensed health care provider" means a licensed health care provider under section 62A.671, subdivision 6, and a mental health practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general supervision of a mental health professional; "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

(f) The limit on coverage of three telemedicine services per enrollee per calendar week does not apply if:

(1) the telemedicine services provided by the licensed health care provider are for the treatment and control of tuberculosis; and

(2) the services are provided in a manner consistent with the recommendations and best practices specified by the Centers for Disease Control and Prevention and the commissioner of health.

Sec. 21. Minnesota Statutes 2018, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. **Dental services.** (a) Medical assistance covers dental services.

(b) Medical assistance dental coverage for nonpregnant adults is limited to the following services:

(1) comprehensive exams, limited to once every five years;

(2) periodic exams, limited to one per year;

(3) limited exams;

(4) bitewing x-rays, limited to one per year;

(5) periapical x-rays;

(6) panoramic x-rays, limited to one every five years except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;

(7) prophylaxis, limited to one per year;

(8) application of fluoride varnish, limited to one per year;

(9) posterior fillings, all at the amalgam rate;

(10) anterior fillings;

(11) endodontics, limited to root canals on the anterior and premolars only;

(12) removable prostheses, each dental arch limited to one every six years;

(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(14) palliative treatment and sedative fillings for relief of pain; ~~and~~

(15) full-mouth debridement, limited to one every five years~~.~~; and

(16) nonsurgical treatment for periodontal disease, including scaling and root planing once every two years for each quadrant, and routine periodontal maintenance procedures.

(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

(1) periodontics, limited to periodontal scaling and root planing once every two years;

(2) general anesthesia; and

(3) full-mouth survey once every five years.

(d) Medical assistance covers medically necessary dental services for children and pregnant women. The following guidelines apply:

(1) posterior fillings are paid at the amalgam rate;

(2) application of sealants are covered once every five years per permanent molar for children only;

(3) application of fluoride varnish is covered once every six months; and

(4) orthodontia is eligible for coverage for children only.

(e) In addition to the services specified in paragraphs (b) and (c), medical assistance covers the following services for adults:

(1) house calls or extended care facility calls for on-site delivery of covered services;

(2) behavioral management when additional staff time is required to accommodate behavioral challenges and sedation is not used;

(3) oral or IV sedation, if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center; and

(4) prophylaxis, in accordance with an appropriate individualized treatment plan, but no more than four times per year.

(f) The commissioner shall not require prior authorization for the services included in paragraph (e), clauses (1) to (3), and shall prohibit managed care and county-based purchasing plans from requiring prior authorization for the services included in paragraph (e), clauses (1) to (3), when provided under sections 256B.69, 256B.692, and 256L.12.

Sec. 22. Minnesota Statutes 2018, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner.

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

(1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the Formulary Committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals. ~~Over-the-counter medications must be dispensed in a quantity that is the lowest of: (1) the number of dosage units contained in the manufacturer's original package; (2) the number of dosage units required to complete the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed from a system using retrospective billing, as provided under subdivision 13e, paragraph (b).~~

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

**EFFECTIVE DATE.** This section is effective April 1, 2019, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 23. Minnesota Statutes 2018, section 256B.0625, subdivision 13d, is amended to read:

Subd. 13d. **Drug formulary.** (a) The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the Administrative Procedure Act, but the Formulary Committee shall review and comment on the formulary contents.

(b) The formulary shall not include:

(1) drugs, active pharmaceutical ingredients, or products for which there is no federal funding;

(2) over-the-counter drugs, except as provided in subdivision 13;

~~(3) drugs or active pharmaceutical ingredients used for weight loss, except that medically necessary lipase inhibitors may be covered for a recipient with type II diabetes;~~

~~(4)~~ (3) drugs or active pharmaceutical ingredients when used for the treatment of impotence or erectile dysfunction;

~~(5)~~ (4) drugs or active pharmaceutical ingredients for which medical value has not been established;

~~(6)~~ (5) drugs from manufacturers who have not signed a rebate agreement with the Department of Health and Human Services pursuant to section 1927 of title XIX of the Social Security Act; and

~~(7)~~ (6) medical cannabis as defined in section 152.22, subdivision 6.

(c) If a single-source drug used by at least two percent of the fee-for-service medical assistance recipients is removed from the formulary due to the failure of the manufacturer to sign a rebate agreement with the Department of Health and Human Services, the commissioner shall notify prescribing practitioners within 30 days of receiving notification from the Centers for Medicare and Medicaid Services (CMS) that a rebate agreement was not signed.

Sec. 24. Minnesota Statutes 2018, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the ~~actual acquisition~~ ingredient costs of the drugs ~~or the maximum allowable cost by the commissioner~~ plus the ~~fixed~~ professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The ~~pharmacy~~ professional dispensing fee shall be ~~$3.65~~ $10.48 for ~~legend prescription drugs, except that~~ prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions ~~which~~ that must be compounded by the pharmacist shall be ~~$8~~ $10.48 per bag~~, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter~~. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be $10.48 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses

a quantity less than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered outpatient drugs shall be $3.65~~, except that the fee shall be $1.31 for retrospectively billing pharmacies when billing for quantities less than the number of units contained in the manufacturer's original package. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. A "designated rural area" means an area defined as a small rural area or isolated rural area according to the four-category classification of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration. Effective January 1, 2014, the actual acquisition~~ for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The National Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug. For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug ~~acquired through~~ for a provider participating in the federal 340B Drug Pricing Program shall be ~~estimated by the commissioner at wholesale acquisition cost minus 40 percent~~ either the 340B Drug Pricing Program ceiling price established by the Health Resources and Services Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to~~, but~~ the actual acquisition cost of the drug product and no higher than~~, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs~~ the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) Pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system meeting the requirements of section 151.58, or a

packaging system meeting the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ retrospective billing for prescription drugs dispensed to long-term care facility residents. A retrospectively billing pharmacy must submit a claim only for the quantity of medication used by the enrolled recipient during the defined billing period. A retrospectively billing pharmacy must use a billing period not less than one calendar month or 30 days.

(c) ~~An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse.~~ A pharmacy provider using packaging that meets the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(d) ~~Whenever a maximum allowable cost has been set for~~ If a pharmacy dispenses a multisource drug, ~~payment shall be the lower of the usual and customary price charged to the public or~~ the ingredient cost shall be the NADAC of the generic product or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider, the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. ~~Effective January 1, 2014,~~ The commissioner shall discount the payment rate for drugs

obtained through the federal 340B Drug Pricing Program by ~~20~~ 28.6 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

(f) The commissioner may ~~negotiate lower reimbursement~~ establish maximum allowable cost rates for specialty pharmacy products ~~than the rates~~ that are lower than the ingredient cost formulas specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the Formulary Committee to develop a list of specialty pharmacy products subject to ~~this paragraph~~ maximum allowable cost reimbursement. In consulting with the Formulary Committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the ~~reimbursement rate~~ maximum allowable cost to prevent access to care issues.

(g) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

(h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey for all pharmacies that are physically located in the state of Minnesota that dispense outpatient drugs under medical assistance. The commissioner shall ensure that the vendor has prior experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the department to dispense outpatient prescription drugs to fee-for-service members must respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The commissioner shall require the vendor to measure a single statewide cost of dispensing for all responding pharmacies to measure the mean, mean weighted by total prescription volume, mean weighted by medical assistance prescription volume, median, median weighted by total prescription volume, and median weighted by total medical assistance prescription volume. The commissioner shall post a

copy of the final cost of dispensing survey report on the department's website. The initial survey must be completed no later than January 1, 2021, and repeated every three years. The commissioner shall provide a summary of the results of each cost of dispensing survey and provide recommendations for any changes to the dispensing fee to the chairs and ranking members of the legislative committees with jurisdiction over medical assistance pharmacy reimbursement.

(i) The commissioner shall increase the ingredient cost reimbursement calculated in paragraphs (a) and (f) by two percent for prescription and nonprescription drugs subject to the wholesale drug distributor tax under section 295.52.

**EFFECTIVE DATE.** This section is effective April 1, 2019, or upon federal approval, whichever is later. Paragraph (i) expires if federal approval is denied. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained or denied.

Sec. 25. Minnesota Statutes 2018, section 256B.0625, subdivision 13f, is amended to read:

Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and recommend drugs which require prior authorization. The Formulary Committee shall establish general criteria to be used for the prior authorization of brand-name drugs for which generically equivalent drugs are available, but the committee is not required to review each brand-name drug for which a generically equivalent drug is available.

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Formulary Committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the Formulary Committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs, information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from the state Medicaid program if such data is available;

(2) the Formulary Committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

(3) the Formulary Committee must hold a public forum and receive public comment for an additional 15 days.

The commissioner must provide a 15-day notice period before implementing the prior authorization.

(c) Except as provided in subdivision 13j, prior authorization shall not be required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:

(1) there is no generically equivalent drug available; and

(2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

(3) the drug is part of the recipient's current course of treatment.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner. Prior authorization shall automatically be granted for 60 days for brand name drugs prescribed for treatment of mental illness within 60 days of when a generically equivalent drug becomes available, provided that the brand name drug was part of the recipient's course of treatment at the time the generically equivalent drug became available.

~~(d) Prior authorization shall not be required or utilized for any antihemophilic factor drug prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available if the prior authorization is used in conjunction with any supplemental drug rebate program or multistate preferred drug list established or administered by the commissioner.~~

~~(e)~~ (d) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates "dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

~~(f)~~ (e) Notwithstanding this subdivision, the commissioner may automatically require prior authorization, for a period not to exceed 180 days, for any drug that is approved by the United States Food and Drug Administration on or after July 1, 2005. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Formulary Committee shall recommend to the commissioner general criteria to be used for the prior authorization of the drugs, but the committee is not required to review each individual drug. In order to continue prior authorizations for a drug after the 180-day period has expired, the commissioner must follow the provisions of this subdivision.

(f) Prior authorization under this subdivision shall comply with section 62Q.184.

**EFFECTIVE DATE.** This section is effective the day following final enactment, except that paragraph (f) is effective July 1, 2019.

Sec. 26. Minnesota Statutes 2018, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service" means motor vehicle transportation provided by a public or private person that serves Minnesota health care program beneficiaries who do not require emergency ambulance service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

(b) Medical assistance covers medical transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, nonemergency medical transportation company, or other recognized providers of transportation services. Medical transportation must be provided by:

(1) nonemergency medical transportation providers who meet the requirements of this subdivision;

(2) ambulances, as defined in section 144E.001, subdivision 2;

(3) taxicabs that meet the requirements of this subdivision;

(4) public transit, as defined in section 174.22, subdivision 7; or

(5) not-for-hire vehicles, including volunteer drivers.

(c) Medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and ~~in consultation with the Minnesota Department of Transportation~~ all drivers must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service. All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

(d) An organization may be terminated, denied, or suspended from enrollment if:

(1) the provider has not initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

(2) the provider has initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

(i) the commissioner has sent the provider a notice that the individual has been disqualified under section 245C.14; and

(ii) the individual has not received a disqualification set-aside specific to the special transportation services provider under sections 245C.22 and 245C.23.

(e) The administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee;

(2) pay nonemergency medical transportation providers for services provided to Minnesota health care programs beneficiaries to obtain covered medical services;

(3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled trips, and number of trips by mode; and

(4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single administrative structure assessment tool that meets the technical requirements established by the commissioner, reconciles trip information with claims being submitted by providers, and ensures prompt payment for nonemergency medical transportation services.

(f) Until the commissioner implements the single administrative structure and delivery system under subdivision 18e, clients shall obtain their level-of-service certificate from the commissioner or an entity approved by the commissioner that does not dispatch rides for clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).

(g) The commissioner may use an order by the recipient's attending physician or a medical or mental health professional to certify that the recipient requires nonemergency medical transportation services. Nonemergency medical transportation providers shall perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

Nonemergency medical transportation providers must take clients to the health care provider using the most direct route, and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the local agency.

Nonemergency medical transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Nonemergency medical transportation providers must maintain trip logs, which include pickup and drop-off times, signed by the medical provider or client, whichever is deemed most appropriate, attesting to mileage traveled to obtain covered medical services. Clients requesting client mileage reimbursement must sign the trip log attesting mileage traveled to obtain covered medical services.

(h) The administrative agency shall use the level of service process established by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee to determine the client's most appropriate mode of transportation. If public transit or a certified transportation provider is not available to provide the appropriate service mode for the client, the client may receive a onetime service upgrade.

(i) The covered modes of transportation are:

(1) client reimbursement, which includes client mileage reimbursement provided to clients who have their own transportation, or to family or an acquaintance who provides transportation to the client;

(2) volunteer transport, which includes transportation by volunteers using their own vehicle;

(3) unassisted transport, which includes transportation provided to a client by a taxicab or public transit. If a taxicab or public transit is not available, the client can receive transportation from another nonemergency medical transportation provider;

(4) assisted transport, which includes transport provided to clients who require assistance by a nonemergency medical transportation provider;

(5) lift-equipped/ramp transport, which includes transport provided to a client who is dependent on a device and requires a nonemergency medical transportation provider with a vehicle containing a lift or ramp;

(6) protected transport, which includes transport provided to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and (ii) who is certified as a protected transport provider; and

(7) stretcher transport, which includes transport for a client in a prone or supine position and requires a nonemergency medical transportation provider with a vehicle that can transport a client in a prone or supine position.

(j) The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the commissioner has developed, made available, and funded the web-based single administrative structure, assessment tool, and level of need assessment under subdivision 18e. The local agency's financial obligation is limited to funds provided by the state or federal government.

(k) The commissioner shall:

(1) in consultation with the Nonemergency Medical Transportation Advisory Committee, verify that the mode and use of nonemergency medical transportation is appropriate;

(2) verify that the client is going to an approved medical appointment; and

(3) investigate all complaints and appeals.

(l) The administrative agency shall pay for the services provided in this subdivision and seek reimbursement from the commissioner, if appropriate. As vendors of medical care, local agencies are subject to the provisions in section 256B.041, the sanctions and monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

(m) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (h), not the type of vehicle used to provide the service. The medical assistance reimbursement rates for nonemergency medical transportation services that are payable by or on behalf of the commissioner for nonemergency medical transportation services are:

(1) $0.22 per mile for client reimbursement;

(2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer transport;

(3) equivalent to the standard fare for unassisted transport when provided by public transit, and $11 for the base rate and $1.30 per mile when provided by a nonemergency medical transportation provider;

(4) $13 for the base rate and $1.30 per mile for assisted transport;

(5) $18 for the base rate and $1.55 per mile for lift-equipped/ramp transport;

(6) $75 for the base rate and $2.40 per mile for protected transport; and

(7) $60 for the base rate and $2.40 per mile for stretcher transport, and $9 per trip for an additional attendant if deemed medically necessary.

(n) The base rate for nonemergency medical transportation services in areas defined under RUCA to be super rural is equal to 111.3 percent of the respective base rate in paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation services in areas defined under RUCA to be rural or super rural areas is:

(1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage rate in paragraph (m), clauses (1) to (7); and

(2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage rate in paragraph (m), clauses (1) to (7).

(o) For purposes of reimbursement rates for nonemergency medical transportation services under paragraphs (m) and (n), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies.

(p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural.

(q) The commissioner, when determining reimbursement rates for nonemergency medical transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2).

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 27. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17d. **Transportation services oversight.** The commissioner shall contract with a vendor or dedicate staff to oversee providers of nonemergency medical transportation services pursuant to the commissioner's authority in section 256B.04 and Minnesota Rules, parts 9505.2160 to 9505.2245.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 28. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17e. **Transportation provider termination.** (a) A terminated nonemergency medical transportation provider, including all named individuals on the current enrollment

disclosure form and known or discovered affiliates of the nonemergency medical transportation provider, is not eligible to enroll as a nonemergency medical transportation provider for five years following the termination.

(b) After the five-year period in paragraph (a), if a provider seeks to reenroll as a nonemergency medical transportation provider, the provider must be placed on a one-year probation period. During a provider's probation period the commissioner shall complete unannounced site visits and request documentation to review compliance with program requirements.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 29. Minnesota Statutes 2018, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center (FQHC) that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. ~~A federally qualified health center~~ An FQHC that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, ~~a federally qualified health center~~ an FQHC shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. ~~Federally qualified health centers~~ FQHCs that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), ~~a federally qualified health center~~ an FQHC or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those ~~federally qualified health centers~~ FQHCs and rural health clinics that have applied for essential community provider status within the six-month time

prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For ~~federally qualified health centers~~ FQHCs and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not ~~federally qualified health centers~~ FQHCs or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring ~~a federally qualified health center~~ an FQHC or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, through December 31, 2020, each ~~federally qualified health center~~ FQHC and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) Effective for services provided on or after January 1, 2021, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner, according to an annual election by the FQHC or rural health clinic, under the current prospective payment system described in paragraph (f) or the alternative payment methodology described in paragraph (l).

(h) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

~~(h)~~ (i) Effective for services provided on or after January 1, 2015, all claims for payment of clinic services provided by ~~federally qualified health centers~~ FQHCs and rural health clinics shall be paid by the commissioner. the commissioner shall determine the most feasible method for paying claims from the following options:

(1) ~~federally qualified health centers~~ FQHCs and rural health clinics submit claims directly to the commissioner for payment, and the commissioner provides claims information for recipients enrolled in a managed care or county-based purchasing plan to the plan, on a regular basis; or

(2) ~~federally qualified health centers~~ FQHCs and rural health clinics submit claims for recipients enrolled in a managed care or county-based purchasing plan to the plan, and those claims are submitted by the plan to the commissioner for payment to the clinic.

~~(i)~~ (j) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics, and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1, 2017. Upon final agreement between the commissioner and a clinic on issues identified under this subdivision, and in accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

~~(j)~~ (k) The commissioner shall seek a federal waiver, authorized under section 1115 of the Social Security Act, to obtain federal financial participation at the 100 percent federal matching percentage available to facilities of the Indian Health Service or tribal organization in accordance with section 1905(b) of the Social Security Act for expenditures made to organizations dually certified under Title V of the Indian Health Care Improvement Act, Public Law 94-437, and as a federally qualified health center under paragraph (a) that provides services to American Indian and Alaskan Native individuals eligible for services under this subdivision.

(l) All claims for payment of clinic services provided by FQHCs and rural health clinics, that have elected to be paid under this paragraph, shall be paid by the commissioner according to the following requirements:

(1) the commissioner shall establish a single medical and single dental organization rate for each FQHC and rural health clinic when applicable;

(2) each FQHC and rural health clinic is eligible for same day reimbursement of one medical and one dental organization rate if eligible medical and dental visits are provided on the same day;

(3) the commissioner shall reimburse FQHCs and rural health clinics, in accordance with current applicable Medicare cost principles, their allowable costs, including direct patient care costs and patient-related support services. Nonallowable costs include, but are not limited to:

(i) general social service and administrative costs;

(ii) retail pharmacy;

(iii) patient incentives, food, housing assistance, and utility assistance;

(iv) external lab and x-ray;

(v) navigation services;

(vi) health care taxes;

(vii) advertising, public relations, and marketing;

(viii) office entertainment costs, food, alcohol, and gifts;

(ix) contributions and donations;

(x) bad debts or losses on awards or contracts;

(xi) fines, penalties, damages, or other settlements;

(xii) fund-raising, investment management, and associated administrative costs;

(xiii) research and associated administrative costs;

(xiv) nonpaid workers;

(xv) lobbying;

(xvi) scholarships and student aid; and

(xvii) nonmedical assistance covered services;

(4) the commissioner shall review the list of nonallowable costs in the years between the rebasing process established in clause (5), in consultation with the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall publish the list and any updates in the Minnesota health care programs provider manual;

(5) the initial applicable base year organization rates for FQHCs and rural health clinics shall be computed for services delivered on or after January 1, 2021, and:

(i) must be determined using each FQHC's and rural health clinic's Medicare cost reports from both 2017 and 2018;

(ii) must be according to current applicable Medicare cost principles as applicable to FQHCs and rural health clinics without the application of productivity screens and upper payment limits or the Medicare prospective payment system FQHC aggregate mean upper payment limit;

(iii) must be subsequently rebased every two years thereafter using the Medicare cost reports that are three and four years prior to the rebasing year;

(iv) must be inflated to the base year using the inflation factor described in clause (6); and

(v) the commissioner must provide for a 60-day appeals process under section 14.57;

(6) the commissioner shall annually inflate the applicable organization rates for FQHCs and rural health clinics from the base year payment rate to the effective date by using the CMS FQHC Market Basket inflator established under United States Code, title 42, section 1395m(o), less productivity;

(7) FQHCs and rural health clinics that have elected the alternative payment methodology under this paragraph shall submit all necessary documentation required by the commissioner to compute the rebased organization rates no later than six months following the date the applicable Medicare cost reports are due to the Centers for Medicare and Medicaid Services;

(8) the commissioner shall reimburse FQHCs and rural health clinics an additional amount relative to their medical and dental organization rates that is attributable to the tax required to be paid according to section 295.52, if applicable;

(9) FQHCs and rural health clinics may submit change of scope requests to the commissioner if the change of scope would result in an increase or decrease of 2.5 percent or higher in the medical or dental organization rate currently received by the FQHC or rural health clinic;

(10) For FQHCs and rural health clinics seeking a change in scope with the commissioner under clause (9) that requires the approval of the scope change by the federal Health Resources Services Administration:

(i) FQHCs and rural health clinics shall submit the change of scope request, including the start date of services, to the commissioner within seven business days of submission of the scope change to the federal Health Resources Services Administration;

(ii) the commissioner shall establish the effective date of the payment change as the federal Health Resources Services Administration date of approval of the FQHC's or rural health clinic's scope change request, or the effective start date of services, whichever is later; and

(iii) within 45 days of one year after the effective date established in item (ii), the commissioner shall conduct a retroactive review to determine if the actual costs established under clause (3) or encounters result in an increase or decrease of 2.5 percent or higher in the medical or dental organization rate, and if this is the case, the commissioner shall revise the rate accordingly and shall adjust payments retrospectively to the effective date established in item (ii);

(11) for change of scope requests that do not require federal Health Resources Services Administration approval, the FQHC and rural health clinic shall submit the request to the commissioner before implementing the change, and the effective date of the change is the date the commissioner received the FQHC's or rural health clinic's request, or the effective start date of the service, whichever is later. The commissioner shall provide a response to the FQHC's or rural health clinic's request within 45 days of submission and provide a final approval within 120 days of submission. This timeline may be waived at the mutual agreement of the commissioner and the FQHC or rural health clinic if more information is needed to evaluate the request;

(12) the commissioner, when establishing organization rates for new FQHCs and rural health clinics, shall consider the patient caseload of existing FQHCs and rural health clinics in a 60-mile radius for organizations established outside of the seven-county metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan area. If this information is not available, the commissioner may use Medicare cost reports or audited financial statements to establish base rate;

(13) the commissioner shall establish a quality measures workgroup that includes representatives from the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics, to evaluate clinical and nonclinical measures; and

(14) the commissioner shall not disallow or reduce costs that are related to an FQHC's or rural health clinic's participation in health care educational programs to the extent that the costs are not accounted for in the alternative payment methodology encounter rate established in this paragraph.

Sec. 30. Minnesota Statutes 2018, section 256B.0625, subdivision 31, is amended to read:

Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient.

(b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies must enroll as a Medicare provider.

(c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment requirement if:

(1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic, or medical supply;

(2) the vendor serves ten or fewer medical assistance recipients per year;

(3) the commissioner finds that other vendors are not available to provide same or similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

(d) Durable medical equipment means a device or equipment that:

(1) can withstand repeated use;

(2) is generally not useful in the absence of an illness, injury, or disability; and

(3) is provided to correct or accommodate a physiological disorder or physical condition or is generally used primarily for a medical purpose.

(e) Electronic tablets may be considered durable medical equipment if the electronic tablet will be used as an augmentative and alternative communication system as defined under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must be locked in order to prevent use not related to communication.

(f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be locked to prevent use not as an augmentative communication device, a recipient of waiver services may use an electronic tablet for a use not related to communication when the recipient has been authorized under the waiver to receive one or more additional applications that can be loaded onto the electronic tablet, such that allowing the additional use prevents the purchase of a separate electronic tablet with waiver funds.

(g) An order or prescription for medical supplies, equipment, or appliances must meet the requirements in Code of Federal Regulations, title 42, part 440.70.

(h) Allergen-reducing products provided according to subdivision 66, paragraph (c), shall be considered durable medical equipment.

**EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 31. Minnesota Statutes 2018, section 256B.0625, subdivision 57, is amended to read:

Subd. 57. **Payment for Part B Medicare crossover claims.** (a) Effective for services provided on or after January 1, 2012, medical assistance payment for an enrollee's cost-sharing associated with Medicare Part B is limited to an amount up to the medical assistance total allowed, when the medical assistance rate exceeds the amount paid by Medicare.

(b) Excluded from this limitation are payments for mental health services and payments for dialysis services provided to end-stage renal disease patients. The exclusion for mental health services does not apply to payments for physician services provided by psychiatrists and advanced practice nurses with a specialty in mental health.

(c) Excluded from this limitation are payments to federally qualified health centers, Indian Health Services, and rural health clinics.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 32. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 66. **Enhanced asthma care services.** (a) Medical assistance covers enhanced asthma care services and related products to be provided in the children's homes for children with poorly controlled asthma. To be eligible for services and products under this subdivision, a child must:

(1) be under the age of 21;

(2) have poorly controlled asthma defined by having received health care for the child's asthma from a hospital emergency department at least one time in the past year or have been hospitalized for the treatment of asthma at least one time in the past year; and

(3) receive a referral for services and products under this subdivision from a treating health care provider.

(b) Covered services include home visits provided by a registered environmental health specialist or lead risk assessor currently credentialed by the Department of Health or a healthy homes specialist credentialed by the Building Performance Institute.

(c) Covered products include the following allergen-reducing products that are identified as needed, and recommended for the child, by a registered environmental health specialist, healthy homes specialist, lead risk assessor, certified asthma educator, public health nurse, or other health care professional providing asthma care for the child, and proven to reduce asthma triggers:

(1) allergen encasements for mattresses, box springs, and pillows;

(2) an allergen-rated vacuum cleaner, filters, and bags;

(3) a dehumidifier and filters;

(4) HEPA single-room air cleaners and filters;

(5) integrated pest management, including traps and starter packages of food storage containers;

(6) a damp mopping system;

(7) if the child does not have access to a bed, a waterproof hospital-grade mattress; and

(8) for homeowners only, furnace filters.

The commissioner shall determine additional products that may be covered as new best practices for asthma care are identified.

(d) A home assessment is a home visit to identify asthma triggers in the home and to provide education on trigger-reducing products. A child is limited to two home assessments except that a child may receive an additional home assessment if the child moves to a new home; if a new asthma trigger, including tobacco smoke, enters the home; or if the child's health care provider identifies a new allergy for the child, including an allergy to mold, pests, pets, or dust mites. The commissioner shall determine the frequency with which a child may receive a product listed in paragraph (c), based on the reasonable expected lifetime of the product.

**EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 33. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 67. **Provider tax rate increase.** (a) The commissioner shall increase the total payments to managed care plans under section 256B.69 by an amount equal to the cost increases to the managed care plans from the elimination of:

(1) the exemption from the taxes imposed under section 297I.05, subdivision 5, for premiums paid by the state for medical assistance and the MinnesotaCare program; and

(2) the exemption of gross revenues subject to the taxes imposed under sections 295.50 to 295.57, for payments paid by the state for services provided under medical assistance and the MinnesotaCare program. Any increase based on this clause must be reflected in provider rates paid by the managed care plan unless the managed care plan is a staff model health plan company.

(b) The commissioner shall increase by two percent the fee-for-service payments under medical assistance and the MinnesotaCare program for services subject to the hospital, surgical center, or health care provider taxes under sections 295.50 to 295.57.

Sec. 34. Minnesota Statutes 2018, section 256B.064, subdivision 1a, is amended to read:

Subd. 1a. **Grounds for sanctions against vendors.** (a) The commissioner may impose sanctions against a vendor of medical care for any of the following: (1) fraud, theft, or abuse in connection with the provision of medical care to recipients of public assistance; (2) a pattern of presentment of false or duplicate claims or claims for services not medically necessary; (3) a pattern of making false statements of material facts for the purpose of

obtaining greater compensation than that to which the vendor is legally entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally established under this section; (7) failure to correct errors in the maintenance of health service or financial records for which a fine was imposed or after issuance of a warning by the commissioner; and (8) any reason for which a vendor could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act.

(b) The commissioner may impose sanctions against a pharmacy provider for failure to respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph (h).

**EFFECTIVE DATE.** This section is effective April 1, 2019.

Sec. 35. Minnesota Statutes 2018, section 256B.0659, subdivision 21, is amended to read:

Subd. 21. **Requirements for provider enrollment of personal care assistance provider agencies.** (a) All personal care assistance provider agencies must provide, at the time of enrollment, reenrollment, and revalidation as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the personal care assistance provider agency's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage for each business location providing services. Upon new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If the Medicaid revenue in the previous year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(3) proof of fidelity bond coverage in the amount of $20,000 for each business location providing service;

(4) proof of workers' compensation insurance coverage identifying the business location where personal care assistance services are provided;

(5) proof of liability insurance coverage identifying the business location where personal care assistance services are provided and naming the department as a certificate holder;

~~(6) a description of the personal care assistance provider agency's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;~~

~~(7)~~ (6) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

~~(8)~~ (7) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

~~(9)~~ (8) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

~~(10)~~ (9) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section;

~~(11)~~ (10) documentation of the agency's marketing practices;

~~(12)~~ (11) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

~~(13)~~ (12) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance

providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

~~(14)~~ (13) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before submitting an application for enrollment of the agency as a provider. All personal care assistance provider agencies shall also require qualified professionals to complete the training required by subdivision 13 before submitting an application for enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation

in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

(d) All surety bonds, fidelity bonds, workers compensation insurance, and liability insurance required by this subdivision must be maintained continuously. After initial enrollment, a provider must submit proof of bonds and required coverages at any time at the request of the commissioner. Services provided while there are lapses in coverage are not eligible for payment. Lapses in coverage may result in sanctions, including termination. The commissioner shall send instructions and a due date to submit the requested information to the personal care assistance provider agency.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 36. Minnesota Statutes 2018, section 256B.69, is amended by adding a subdivision to read:

Subd. 38. **Payment rate transparency.** The commissioner shall compare fee-for-service medical assistance, Medicare, and medical assistance managed care and county-based purchasing plan aggregate payment rates for the most frequently used inpatient hospital, primary care, dental care, physician specialist, obstetrics, mental health, substance use disorder, and home health services using available data. The commissioner shall publish this information on the Department of Human Services website and must update the information annually by October 1. The managed care and county-based purchasing plan aggregate payment data must be expressed as the percentage above or below the fee-for-service payment rate for the categories listed in this subdivision.

**EFFECTIVE DATE.** This section is effective October 1, 2020.

Sec. 37. **[256B.758] REIMBURSEMENT FOR DOULA SERVICES.**

Effective for services provided on or after July 1, 2019, payments for doula services provided by a certified doula shall be $47 per prenatal or postpartum visit and $488 for attending and providing doula services at a birth.

Sec. 38. Minnesota Statutes 2018, section 256B.766, is amended to read:

**256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

(a) Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through

June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and related services as basic care services. The reduction in this paragraph shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

(b) Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction effective July 1, 2010.

(c) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

(d) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, and anesthesia services shall be reduced by three percent from the rates in effect on August 31, 2011.

(e) Effective for services provided on or after September 1, 2014, payments for ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory services, public health nursing services, eyeglasses not subject to a volume purchase contract, and hearing aids not subject to a volume purchase contract shall be increased by three percent and payments for outpatient hospital facility fees shall be increased by three percent. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(f) Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics,

provided on or after July 1, 2015, shall be increased by three percent from the rates as determined under paragraphs (i) and (j).

(g) Effective for services provided on or after July 1, 2015, payments for outpatient hospital facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics, and orthotics to a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(h) This section does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.

(i) Effective for services provided on or after July 1, 2015, the following categories of medical supplies and durable medical equipment shall be individually priced items: enteral nutrition and supplies, customized and other specialized tracheostomy tubes and supplies, electric patient lifts, and durable medical equipment repair and service. This paragraph does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, and items provided to dually eligible recipients when Medicare is the primary payer for the item. The commissioner shall not apply any medical assistance rate reductions to durable medical equipment as a result of Medicare competitive bidding.

(j) Effective for services provided on or after July 1, 2015, medical assistance payment rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased as follows:

(1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that were subject to the Medicare competitive bid that took effect in January of 2009 shall be increased by 9.5 percent; and

(2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on the medical assistance fee schedule, whether or not subject to the Medicare competitive bid that took effect in January of 2009, shall be increased by 2.94 percent, with this increase being applied after calculation of any increased payment rate under clause (1).

This paragraph does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, items provided to dually eligible recipients when Medicare is the primary payer

for the item, and individually priced items identified in paragraph (i). Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect the rate increases in this paragraph.

(k) Effective for nonpressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the submitted charge or the Medicare fee schedule rate. Effective for pressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the submitted charge or 47 percent above the Medicare fee schedule rate. For payments made in accordance with this paragraph, if, and to the extent that, the commissioner identifies that the state has received federal financial participation for ventilators in excess of the amount allowed effective January 1, 2018, under United States Code, title 42, section 1396b(i)(27), the state shall repay the excess amount to the Centers for Medicare and Medicaid Services with state funds and maintain the full payment rate under this paragraph.

(l) Payment rates for durable medical equipment, prosthetics, orthotics or supplies, that are subject to the upper payment limit in accordance with section 1903(i)(27) of the Social Security Act, shall be paid the Medicare rate. Rate increases provided in this chapter shall not be applied to the items listed in this paragraph.

**EFFECTIVE DATE.** This section is effective July 1, 2019, subject to federal approval. The commissioner shall notify the revisor of statutes when federal approval has been obtained.

Sec. 39. Minnesota Statutes 2018, section 256L.11, subdivision 2, is amended to read:

Subd. 2. **Payment of certain providers.** Services provided by federally qualified health centers, rural health clinics, ~~and~~ facilities of the Indian health service, and certified community behavioral health clinics shall be paid for according to the same rates and conditions applicable to the same service provided by providers that are not federally qualified health centers, rural health clinics, ~~or~~ facilities of the Indian health service, or certified community behavioral health clinics. The alternative payment methodology described under section 256B.0625, subdivision 30, paragraph (l), shall not apply to services delivered under this chapter by federally qualified health centers, rural health clinics, and facilities of the Indian Health Services. The prospective payment system for certified behavioral health clinics under section 256B.0625, subdivision 5m, shall not apply to services delivered under this chapter.

Sec. 40. Minnesota Statutes 2018, section 295.52, subdivision 8, is amended to read:

Subd. 8. **Contingent reduction in tax rate.** (a) By December 1 of each year, beginning in 2011, the commissioner of management and budget shall determine the projected balance in the health care access fund for the biennium.

(b) If the commissioner of management and budget determines that the projected balance in the health care access fund for the biennium reflects a ratio of revenues to expenditures and transfers greater than 125 percent, and if the actual cash balance in the fund is adequate, as determined by the commissioner of management and budget, the commissioner, in consultation with the commissioner of revenue, shall reduce the tax rates levied under subdivisions 1, 1a, 2, 3, and 4, for the subsequent calendar year sufficient to reduce the structural balance in the fund. The rate may be reduced to the extent that the projected revenues for the biennium do not exceed 125 percent of expenditures and transfers. The new rate shall be rounded to the nearest one-tenth of one percent. The rate reduction under this paragraph expires at the end of each calendar year and is subject to an annual redetermination by the commissioner of management and budget.

(c) For purposes of the analysis defined in paragraph (b), the commissioner of management and budget shall include projected revenues~~, notwithstanding the repeal of the tax imposed under this section effective January 1, 2020~~.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 41. Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6, as amended by Laws 2004, chapter 272, article 2, section 4; Laws 2005, First Special Session chapter 4, article 5, section 18; and Laws 2005, First Special Session chapter 4, article 9, section 11, is amended to read:

Subd. 6. **Basic Health Care Grants**

| | Summary by Fund | |
|---|---|---|
| General | 1,290,454,000 | 1,475,996,000 |
| Health Care Access | 254,121,000 | 282,689,000 |

**UPDATING FEDERAL POVERTY GUIDELINES.** Annual updates to the federal poverty guidelines are effective each July 1, following publication by the United States Department of Health and Human Services

for health care programs under Minnesota Statutes, chapters 256, 256B, 256D, and 256L.

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) MinnesotaCare Grants

| | | |
|---|---|---|
| Health Care Access | 253,371,000 | 281,939,000 |

**MINNESOTACARE FEDERAL RECEIPTS.** Receipts received as a result of federal participation pertaining to administrative costs of the Minnesota health care reform waiver shall be deposited as nondedicated revenue in the health care access fund. Receipts received as a result of federal participation pertaining to grants shall be deposited in the federal fund and shall offset health care access funds for payments to providers.

**MINNESOTACARE FUNDING.** The commissioner may expend money appropriated from the health care access fund for MinnesotaCare in either fiscal year of the biennium.

(b) MA Basic Health Care Grants - Families and Children

| | | |
|---|---|---|
| General | 427,769,000 | 489,545,000 |

**SERVICES TO PREGNANT WOMEN.** The commissioner shall use available federal money for the State-Children's Health Insurance Program for medical assistance services provided to pregnant women who are not otherwise eligible for federal financial participation beginning in fiscal year 2003. This federal money shall be deposited in the

federal fund and shall offset general funds for payments to providers. Notwithstanding section 14, this paragraph shall not expire.

**MANAGED CARE RATE INCREASE.** ~~(a) Effective January 1, 2004, the commissioner of human services shall increase the total payments to managed care plans under Minnesota Statutes, section 256B.69, by an amount equal to the cost increases to the managed care plans from by the elimination of: (1) the exemption from the taxes imposed under Minnesota Statutes, section 297I.05, subdivision 5, for premiums paid by the state for medical assistance, general assistance medical care, and the MinnesotaCare program; and (2) the exemption of gross revenues subject to the taxes imposed under Minnesota Statutes, sections 295.50 to 295.57, for payments paid by the state for services provided under medical assistance, general assistance medical care, and the MinnesotaCare program. Any increase based on clause (2) must be reflected in provider rates paid by the managed care plan unless the managed care plan is a staff model health plan company.~~

~~(b) The commissioner of human services shall increase by the applicable tax rate in effect under Minnesota Statutes, section 295.52, the fee-for-service payments under medical assistance, general assistance medical care, and the MinnesotaCare program for services subject to the hospital, surgical center, or health care provider taxes under Minnesota Statutes, sections 295.50 to 295.57, effective~~

~~for services rendered on or after January 1, 2004.~~

(c) The commissioner of finance shall transfer from the health care access fund to the general fund the following amounts in the fiscal years indicated: 2004, $16,587,000; 2005, $46,322,000; 2006, $49,413,000; and 2007, $58,695,000.

(d) Notwithstanding section 14, these provisions shall not expire.

(c) MA Basic Health Care Grants - Elderly and Disabled

| | | |
|---|---|---|
| General | 610,518,000 | 743,858,000 |

**DELAY MEDICAL ASSISTANCE FEE-FOR-SERVICE - ACUTE CARE.** The following payments in fiscal year 2005 from the Medicaid Management Information System that would otherwise have been made to providers for medical assistance and general assistance medical care services shall be delayed and included in the first payment in fiscal year 2006:

(1) for hospitals, the last two payments; and

(2) for nonhospital providers, the last payment.

This payment delay shall not include payments to skilled nursing facilities, intermediate care facilities for mental retardation, prepaid health plans, home health agencies, personal care nursing providers, and providers of only waiver services. The provisions of Minnesota Statutes, section 16A.124, shall not apply to these delayed payments. Notwithstanding section 14, this provision shall not expire.

**DEAF AND HARD-OF-HEARING SERVICES.** If, after making reasonable efforts, the service provider for mental health services to persons who are deaf or hearing impaired is not able to earn $227,000 through participation in medical assistance intensive rehabilitation services in fiscal year 2005, the commissioner shall transfer $227,000 minus medical assistance earnings achieved by the grantee to deaf and hard-of-hearing grants to enable the provider to continue providing services to eligible persons.

(d) General Assistance Medical Care Grants

| | | |
|---|---|---|
| General | 239,861,000 | 229,960,000 |

(e) Health Care Grants - Other Assistance

| | | |
|---|---|---|
| General | 3,067,000 | 3,407,000 |
| Health Care Access | 750,000 | 750,000 |

**MINNESOTA PRESCRIPTION DRUG DEDICATED FUND.** Of the general fund appropriation, $284,000 in fiscal year 2005 is appropriated to the commissioner for the prescription drug dedicated fund established under the prescription drug discount program.

**DENTAL ACCESS GRANTS CARRYOVER AUTHORITY.** Any unspent portion of the appropriation from the health care access fund in fiscal years 2002 and 2003 for dental access grants under Minnesota Statutes, section 256B.53, shall not cancel but shall be allowed to carry forward to be spent in the biennium beginning July 1, 2003, for these purposes.

**STOP-LOSS FUND ACCOUNT.** The appropriation to the purchasing alliance

stop-loss fund account established under Minnesota Statutes, section 256.956, subdivision 2, for fiscal years 2004 and 2005 shall only be available for claim reimbursements for qualifying enrollees who are members of purchasing alliances that meet the requirements described under Minnesota Statutes, section 256.956, subdivision 1, paragraph (f), clauses (1), (2), and (3).

(f) Prescription Drug Program

| | | |
|---|---|---|
| General | 9,239,000 | 9,226,000 |

**PRESCRIPTION DRUG ASSISTANCE PROGRAM.** Of the general fund appropriation, $702,000 in fiscal year 2004 and $887,000 in fiscal year 2005 are for the commissioner to establish and administer the prescription drug assistance program through the Minnesota board on aging.

**REBATE REVENUE RECAPTURE.** Any funds received by the state from a drug manufacturer due to errors in the pharmaceutical pricing used by the manufacturer in determining the prescription drug rebate are appropriated to the commissioner to augment funding of the prescription drug program established in Minnesota Statutes, section 256.955.

Sec. 42. **STUDY OF CLINIC COSTS.**

The commissioner of human services shall conduct a five-year comparative analysis of the actual change in aggregate federally qualified health center (FQHC) and rural health clinic costs versus the CMS FQHC Market Basket inflator using 2017 through 2022 finalized Medicare Cost Reports, CMS 2224-14, and report the findings to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, by July 1, 2025.

Sec. 43. **REPEALER.**

(a) Minnesota Statutes 2018, sections 256B.0625, subdivision 63; 256B.0659, subdivision 22; and 256L.11, subdivision 2a, are repealed.

(b) Laws 2011, First Special Session chapter 9, article 6, section 97, subdivision 6, is repealed effective the day following final enactment.

## ARTICLE 9
## ONECARE

Section 1. Minnesota Statutes 2018, section 62J.497, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

(b) "Backward compatible" means that the newer version of a data transmission standard would retain, at a minimum, the full functionality of the versions previously adopted, and would permit the successful completion of the applicable transactions with entities that continue to use the older versions.

(c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(d) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

(e) "Electronic media" has the meaning given under Code of Federal Regulations, title 45, part 160.103.

(f) "E-prescribing" means the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser and two-way transmissions related to eligibility, formulary, and medication history information.

(g) "Electronic prescription drug program" means a program that provides for e-prescribing.

(h) "Group purchaser" has the meaning given in section 62J.03, subdivision 6~~.~~, excluding state and federal health care programs under chapters 256B, 256L, and 256T.

(i) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

(j) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

(k) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

(l) "NCPDP Formulary and Benefits Standard" means the National Council for Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide, Version 1, Release 0, October 2005.

(m) "NCPDP SCRIPT Standard" means the National Council for Prescription Drug Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide Version 8, Release 1 (Version 8.1), October 2005, or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance. Subsequently released versions of the NCPDP SCRIPT Standard may be used, provided that the new version of the standard is backward compatible to the current version adopted by the Centers for Medicare and Medicaid Services.

(n) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

(o) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as defined in section 151.01, subdivision 23.

(p) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

(q) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

**EFFECTIVE DATE.** This section is effective January 1, 2022.

Sec. 2. **[62V.12] ADVANCED PAYMENT OF STATE-BASED HEALTH INSURANCE PREMIUM TAX CREDIT.**

Subdivision 1. **Determination of eligibility for advanced payment of state-based health insurance premium tax credit.** (a) The Board of Directors of MNsure shall assess an individual's eligibility for an advanced payment of the state-based health insurance tax credit under section 290.0693 when an individual applies for an eligibility determination through MNsure, basing the eligibility determination upon income for the relevant tax year

as projected by the individual. MNsure shall equally divide the value of the potential state-based tax credit across the monthly premiums to be charged to the individual. If the individual selects a plan through MNsure, MNsure shall notify the relevant health carrier of the amount of the advanced payment of the state-based insurance premium tax credit amount and direct the health carrier to deduct the amount from the eligible individual's premiums.

(b) An individual is eligible for an advanced payment of the state-based health insurance premium tax credit if they are a Minnesota resident who:

(1) had at least one month of coverage by a qualified health plan offered through MNsure during the tax year;

(2) was not enrolled in public program coverage under section 256B.055 or 256L.04 during the months of coverage by the qualified health plan; and

(3) is eligible for the health insurance tax credit in section 290.0693.

(c) To be eligible for an advanced payment of the state-based health insurance premium tax credit, the individual must attest that the individual will file a state tax return in order to reconcile any advanced payment of the credit and will file a joint tax return with their spouse, if married.

(d) An individual is not eligible for an advanced payment of the state-based health insurance premium tax credit for the taxable year if MNsure is notified by the commissioner of revenue that the individual received an advanced payment in a prior tax year and has not filed a tax return for the relevant tax year and has not fully paid any amount necessary to reconcile the advanced payment.

Subd. 2. **Payments to health carriers.** The board shall make payments to health carriers equal to the amount of the advance state-based health insurance premium tax credit amounts provided to eligible individuals effectuating coverage for the months in which the individual has paid the net premium amount to the health carrier.

Subd. 3. **Health carrier responsibilities.** A health carrier that receives notice from MNsure that an individual enrolled in the health carrier's qualified health plan is eligible for an advanced payment of the state-based health insurance premium tax credit shall:

(1) reduce the portion of the premium charged to the individual for the applicable months by the amount of the state-based health insurance tax credit determined by MNsure;

(2) include the amount of advanced state-based health insurance premium tax credit determined by MNsure on each billing statement for which an advanced state-based health insurance tax credit has been applied; and

(3) reconcile advanced payments of state-based health insurance premium tax credits with MNsure at least once a month.

Subd. 4. **Appeals.** MNsure appeals are available for Minnesota residents for initial determinations and redeterminations made by MNsure of eligibility for and level of an advanced payment of the state-based health insurance premium tax credit. The appeals must follow the procedures enumerated in Minnesota Rules, chapter 7700.

Subd. 5. **Data practices.** The data classifications in section 62V.06, subdivision 3, apply to data on individuals applying for or receiving a state-based health insurance tax credit pursuant to this subdivision.

Subd. 6. **Data sharing.** Notwithstanding any law to the contrary, the board is permitted to share or disseminate data in subdivision 5 as described in section 62V.06, subdivision 5.

Subd. 7. **Appropriations.** Beginning in fiscal year 2021 and each fiscal year thereafter, an amount sufficient to make advanced payments of the state-based health insurance tax credit is appropriated from the health care access fund to the board for payment of advanced state-based health insurance premium tax credits under this section.

**EFFECTIVE DATE.** This section is effective for advanced payment of the state-based health insurance premium tax credit applied to premiums for plan years 2021 and beyond.

Sec. 3. **[62V.13] DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of sections 62V.13 to 62V.133, the following terms have the meanings given.

Subd. 2. **Board.** "Board" means the board of directors of MNsure specified in section 62V.04.

Subd. 3. **Eligible individual.** "Eligible individual" means a Minnesota resident who:

(1) is determined not eligible to receive an advance credit payment under Code of Federal Regulations, title 26, section 1.36B-1(j), of the premium tax credit under Code of Federal Regulations, title 26, section 1.36B-2, for a given month of coverage;

(2) is not enrolled in public program coverage under section 256B.055 or 256L.04; and

(3) purchased a qualified health plan through MNsure.

Subd. 4. **Gross premium.** "Gross premium" means the amount billed for a qualified health plan purchased by an eligible individual prior to a premium subsidy or advanced state-based tax credit being applied in a calendar year.

Subd. 5. **Health carrier.** "Health carrier" has the meaning given in section 62A.011, subdivision 2.

Subd. 6. **MNsure.** "MNsure" means the state health benefit exchange as described in section 1311 of the federal Patient Protection and Affordable Care Act, Public Law 111-148, and chapter 62V.

Subd. 7. **Net premium.** "Net premium" means the gross premium less the premium subsidy.

Subd. 8. **Premium subsidy.** "Premium subsidy":

(1) is a rebate payment to discount the cost of insurance for the promotion of general welfare, and is not compensation for any services;

(2) is equal to 20 percent of the monthly gross premium otherwise paid by or on behalf of the eligible individual for qualified health plan coverage purchased through MNsure that covers the eligible individual and the eligible individual's covered spouse and covered dependents; and

(3) is excluded from any calculation used to determine eligibility within any of the Department of Human Services programs.

Subd. 9. **Qualified health plan.** "Qualified health plan" means a health plan that meets the definition in section 1301(a) of the Affordable Care Act, Public Law 111-148, and has been certified by the board in accordance with section 62V.05, subdivision 5, to be offered through MNsure.

Sec. 4. **[62V.131] PAYMENT TO HEALTH CARRIERS ON BEHALF OF ELIGIBLE INDIVIDUALS.**

Subdivision 1. **Program established.** The board shall establish and administer the premium subsidy program authorized by this act to help eligible individuals pay for coverage when purchasing qualified health plans through MNsure in plan year 2020 and in each subsequent plan year for which an appropriation is approved.

Subd. 2. **Administration.** MNsure shall determine if an individual applying for coverage through MNsure is an eligible individual. If so, MNsure shall calculate the proper amount of the eligible individual's premium subsidy. MNsure shall notify the relevant health carrier

of the premium subsidy amount and direct the health carrier to deduct the premium subsidy amount from the eligible individual's gross premium as a discount to the eligible individual's qualified health plan premium.

Subd. 3. **Payments to health carriers.** (a) The board shall make payments to health carriers equal to the amount of the premium subsidy discounts provided to eligible individuals effectuating coverage for the months in which the individual has paid the net premium amount to the health carrier. Payments to health carriers shall be based on the premium subsidy provided on behalf of eligible individuals, regardless of the cost of coverage purchased.

(b) Health carriers seeking reimbursement from the board must submit an invoice and supporting information to the board using a format and method developed by the board in order to be determined to be eligible for payment.

(c) The board shall consider health carriers as vendors under section 16A.124, subdivision 3, and each monthly invoice shall represent the completed delivery of the service.

Subd. 4. **Data practices.** The data classifications in section 62V.06, subdivision 3, apply to data on individuals applying for or receiving a premium subsidy under this subdivision.

Subd. 5. **Data sharing.** Notwithstanding any law to the contrary, the board is permitted to share or disseminate the data in subdivision 4 as described in section 62V.06, subdivision 5.

Sec. 5. **[62V.132] APPEALS.**

MNsure appeals are available for Minnesota residents for initial determinations and redeterminations made by MNsure of eligibility for and level of premium subsidy and should follow the procedures enumerated in Minnesota Rules, chapter 7700.

Sec. 6. **[62V.133] APPLICABILITY OF GROSS PREMIUM.**

Notwithstanding premium subsidies provided under section 62V.131, the premium base for calculating the amount of any applicable premium taxes under chapter 297I, shall be the gross premium for a qualified health plan purchased by eligible individuals through MNsure.

Sec. 7. **[256B.0371] ADMINISTRATION OF DENTAL SERVICES.**

(a) Effective January 1, 2022, the commissioner shall contract with a dental administrator to administer dental services for all recipients of medical assistance and MinnesotaCare.

(b) The dental administrator must provide administrative services including but not limited to:

(1) provider recruitment, contracting, and assistance;

(2) recipient outreach and assistance;

(3) utilization management and review for medical necessity of dental services;

(4) dental claims processing;

(5) coordination with other services;

(6) management of fraud and abuse;

(7) monitoring of access to dental services;

(8) performance measurement;

(9) quality improvement and evaluation requirements; and

(10) management of third-party liability requirements.

(c) Payments to contracted dental providers must be at the rates established under section 256B.76.

**EFFECTIVE DATE.** This section is effective January 1, 2022.

Sec. 8. Minnesota Statutes 2018, section 256B.0644, is amended to read:

**256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.**

(a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program and MinnesotaCare as a condition of participating as a provider in health insurance plans and programs or contractor for state employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota Comprehensive Health Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by managed care contracts with the Department of Human Services. This section does not apply to dental service providers providing dental services outside the seven-county metropolitan area.

(b) For providers other than health maintenance organizations, participation in the medical assistance program means that:

(1) the provider accepts new medical assistance and MinnesotaCare patients;

(2) for providers other than dental service providers, at least 20 percent of the provider's patients are covered by medical assistance and MinnesotaCare as their primary source of coverage; or

(3) for dental service providers providing dental services in the seven-county metropolitan area, at least ten percent of the provider's patients are covered by medical assistance and MinnesotaCare as their primary source of coverage, or the provider accepts new medical assistance and MinnesotaCare patients who are children with special health care needs. For purposes of this section, "children with special health care needs" means children up to age 18 who: (i) require health and related services beyond that required by children generally; and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, including: bleeding and coagulation disorders; immunodeficiency disorders; cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other neurological diseases; visual impairment or deafness; Down syndrome and other genetic disorders; autism; fetal alcohol syndrome; and other conditions designated by the commissioner after consultation with representatives of pediatric dental providers and consumers.

(c) Patients seen on a volunteer basis by the provider at a location other than the provider's usual place of practice may be considered in meeting the participation requirement in this section. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of management and budget, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of management and budget shall implement this section through contracts with participating health and dental carriers.

(d) A volunteer dentist who has signed a volunteer agreement under section 256B.0625, subdivision 9a, shall not be considered to be participating in medical assistance or MinnesotaCare for the purpose of this section.

(e) A vendor of medical care, as defined in section 256B.02, subdivision 7, that dispenses outpatient prescription drugs in accordance with chapter 151 must participate as a provider

or contractor in the MinnesotaCare program as a condition of participating as a provider in the medical assistance program.

**EFFECTIVE DATE.** This section is effective January 1, 2022.

Sec. 9. Minnesota Statutes 2018, section 256B.69, subdivision 6d, is amended to read:

Subd. 6d. **Prescription drugs.** The commissioner ~~may~~ shall exclude ~~or modify~~ coverage for prescription drugs from the prepaid managed care contracts entered into under this section ~~in order to increase savings to the state by collecting additional prescription drug rebates. The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and utilization, the contracts may authorize the managed care plans to use preferred drug lists and prior authorization. This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates~~.

**EFFECTIVE DATE.** This section is effective January 1, 2022.

Sec. 10. Minnesota Statutes 2018, section 256B.69, subdivision 35, is amended to read:

Subd. 35. **Statewide procurement.** (a) For calendar year 2015, the commissioner may extend a demonstration provider's contract under this section for a sixth year after the most recent procurement. For calendar year 2015, section 16B.98, subdivision 5, paragraph (b), and section 16C.05, subdivision 2, paragraph (b), shall not apply to contracts under this section.

(b) For calendar year 2016 contracts under this section, the commissioner shall procure through a statewide procurement, which includes all 87 counties, demonstration providers, and participating entities as defined in section 256L.01, subdivision 7. The commissioner shall publish a request for proposals by January 5, 2015. As part of the procurement process, the commissioner shall:

(1) seek each individual county's input;

(2) organize counties into regional groups, and consider single counties for the largest and most diverse counties; and

(3) seek regional and county input regarding the respondent's ability to fully and adequately deliver required health care services, offer an adequate provider network, provide care coordination with county services, and serve special populations, including enrollees with language and cultural needs.

(c) For calendar year 2021, the commissioner may extend a demonstration provider's contract under this section for a sixth year after the most recent procurement, for the provision of services in the seven-county metropolitan area to families and children under medical assistance and MinnesotaCare. For calendar year 2021, sections 16B.98, subdivision 5, paragraph (b), and 16C.06, subdivision 3b, shall not apply to contracts under this section. For calendar year 2022, the commissioner shall procure services in the seven-county metropolitan area for families and children under medical assistance and MinnesotaCare, from demonstration providers and participating entities as defined in section 256L.01, subdivision 7.

Sec. 11. Minnesota Statutes 2018, section 256B.76, subdivision 2, is amended to read:

Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992; and

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

(b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

(c) Effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999.

(d) Effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

(e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000, for managed care.

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal year, a

supplemental state payment equal to the difference between the total payments in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

(h) If the cost-based payment system for state-operated dental clinics described in paragraph (f) does not receive federal approval, then state-operated dental clinics shall be designated as critical access dental providers under subdivision 4, paragraph (b), and shall receive the critical access dental reimbursement rate as described under subdivision 4, paragraph (a).

(i) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for dental services shall be reduced by three percent. This reduction does not apply to state-operated dental clinics in paragraph (f).

(j) Effective for services rendered on or after January 1, 2014, payment rates for dental services shall be increased by five percent from the rates in effect on December 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2014, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in this paragraph.

(k) Effective for services rendered on or after July 1, 2015, through December 31, 2016, the commissioner shall increase payment rates for services furnished by dental providers located outside of the seven-county metropolitan area by the maximum percentage possible above the rates in effect on June 30, 2015, while remaining within the limits of funding appropriated for this purpose. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2016, through December 31, 2016, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph. The commissioner shall require managed care and county-based purchasing plans to pass on the full amount of the increase, in the form of higher payment rates to dental providers located outside of the seven-county metropolitan area.

(l) Effective for services provided on or after January 1, 2017, through December 31, 2021, the commissioner shall increase payment rates by 9.65 percent for dental services provided outside of the seven-county metropolitan area. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health

centers, or Indian health services. Effective January 1, 2017, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph.

(m) Effective for services provided on or after July 1, 2017, through December 31, 2021, the commissioner shall increase payment rates by 23.8 percent for dental services provided to enrollees under the age of 21. This rate increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health centers. This rate increase does not apply to managed care plans and county-based purchasing plans.

(n) Effective for dental services provided on or after January 1, 2022, the commissioner shall increase payment rates by 54 percent. This rate increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health centers.

Sec. 12. Minnesota Statutes 2018, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) The commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2016, through December 31, 2021, the commissioner shall increase reimbursement by 37.5 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider, except as specified under paragraph (b). The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.

(b) For dental services rendered on or after July 1, 2016, by a dental clinic or dental group that meets the critical access dental provider designation under paragraph (d), clause (4), and is owned and operated by a health maintenance organization licensed under chapter 62D, the commissioner shall increase reimbursement by 35 percent above the reimbursement rate that would otherwise be paid to the critical access provider.

(c) Critical access dental payments made under paragraph (a) or (b) for dental services provided by a critical access dental provider to an enrollee of a managed care plan or county-based purchasing plan must not reflect any capitated payments or cost-based payments from the managed care plan or county-based purchasing plan. The managed care plan or county-based purchasing plan must base the additional critical access dental payment on the amount that would have been paid for that service had the dental provider been paid

according to the managed care plan or county-based purchasing plan's fee schedule that applies to dental providers that are not paid under a capitated payment or cost-based payment.

(d) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

(1) nonprofit community clinics that:

(i) have nonprofit status in accordance with chapter 317A;

(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

(v) charge for services on a sliding fee scale designed to provide assistance to low-income patients based on current poverty income guidelines and family size;

(vi) do not restrict access or services because of a patient's financial limitations or public assistance status; and

(vii) have free care available as needed;

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) hospital-based dental clinics owned and operated by a city, county, or former state hospital as defined in section 62Q.19, subdivision 1, paragraph (a), clause (4);

(4) a dental clinic or dental group owned and operated by a nonprofit corporation in accordance with chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance or MinnesotaCare;

(5) a dental clinic owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system; and

(6) private practicing dentists if:

(i) the dentist's office is located within the seven-county metropolitan area and more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare; or

(ii) the dentist's office is located outside the seven-county metropolitan area and more than 25 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare.

Sec. 13. Minnesota Statutes 2018, section 256L.03, is amended by adding a subdivision to read:

Subd. 7. **Outpatient prescription drugs.** Outpatient prescription drugs are covered according to section 256L.30. This subdivision applies to all individuals enrolled in the MinnesotaCare program.

**EFFECTIVE DATE.** This section is effective January 1, 2022.

Sec. 14. Minnesota Statutes 2018, section 256L.07, subdivision 2, is amended to read:

Subd. 2. **Must not have access to employer-subsidized minimum essential coverage.** (a) To be eligible, a family or individual must not have access to subsidized health coverage that is affordable and provides minimum value as defined in Code of Federal Regulations, title 26, section 1.36B-2.

(b) Notwithstanding paragraph (a), an individual who has access to subsidized health coverage through a spouse's or parent's employer that is deemed minimum essential coverage under Code of Federal Regulations, title 26, section 1.36B-2, is eligible for MinnesotaCare if the portion of the annual premium the employee pays for employee and dependent coverage exceeds the required contribution percentage as described in Code of Federal Regulations, title 26, section 1.36B-2, and the individual meets all other eligibility requirements of this chapter.

~~(b)~~ (c) This subdivision does not apply to a family or individual who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit.

**EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 15. Minnesota Statutes 2018, section 256L.07, is amended by adding a subdivision to read:

Subd. 2b. **Federal waiver.** The commissioner of human services, in consultation with the Board of Directors of MNsure, shall apply for a federal waiver to allow the state to permit a person who has access to employer-sponsored health insurance through a spouse or parent that is deemed minimum essential coverage under Code of Federal Regulations, title 26, section 1.36B-2, and the portion of the annual premium the person pays for employee

and dependent coverage exceeds the required contribution percentage in Code of Federal Regulations, title 26, section 1.36B-2, to:

(1) enroll in the MinnesotaCare program, if the person meets all eligibility requirements, except for section 256L.07, subdivision 2, paragraph (a);

(2) qualify for advanced premium tax credits under Code of Federal Regulations, title 26, section 1.36B-2, and cost sharing reductions under Code of Federal Regulations, title 45, section 155.305(g), if the person meets all eligibility requirements, except for the affordability requirement described in Code of Federal Regulations, title 26, section 1.36B-2 (c)(3)(v)(A)(2); and

(3) qualify to purchase coverage in the OneCare Buy-In pursuant to section 256T.03, if the person meets all eligibility requirements.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 16. Minnesota Statutes 2018, section 256L.11, subdivision 7, is amended to read:

Subd. 7. **Critical access dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after July 1, 2017, through December 31, 2021, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, subdivision 4, by 20 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall pay the prepaid health plans under contract with the commissioner amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers under section 256B.76, subdivision 4.

Sec. 17. **[256L.30] OUTPATIENT PRESCRIPTION DRUGS.**

Subdivision 1. **Establishment of program.** The commissioner shall administer and oversee the outpatient prescription drug program for MinnesotaCare. The commissioner shall not include the outpatient pharmacy benefit in a contract with a public or private entity.

Subd. 2. **Covered outpatient prescription drugs.** (a) In consultation with the Drug Formulary Committee under section 256B.0625, subdivision 13d, the commissioner shall establish an outpatient prescription drug formulary for MinnesotaCare that satisfies the requirements for an essential health benefit under Code of Federal Regulations, title 45, section 156.122. The commissioner may modify the formulary after consulting with the Drug Formulary Committee and providing public notice and the opportunity for public

comment. The commissioner is exempt from the rulemaking requirements of chapter 14 to establish the drug formulary, and section 14.386 does not apply. The commissioner shall make the drug formulary available to the public on the agency website.

(b) The MinnesotaCare formulary must contain at least one drug in every United States Pharmacopeia category and class or the same number of prescription drugs in each category and class as the essential health benefit benchmark plan, whichever is greater.

(c) The commissioner may negotiate drug rebates or discounts directly with a drug manufacturer to place a drug on the formulary. The commissioner may also negotiate drug rebates, or discounts, with a drug manufacturer through a contract with a vendor. The commissioner, beginning January 15, 2022, and each January 15 thereafter, shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance of the rebates and discounts negotiated, their aggregate dollar value, and how the department applied these savings, including the extent to which these savings were passed on to enrollees.

(d) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Drug Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Drug Formulary Committee review a drug for prior authorization.

(e) Before the commissioner requires prior authorization for a drug:

(1) the commissioner must provide the Drug Formulary Committee with information on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs and information regarding whether the drug is subject to clinical abuse or misuse if such data is available; and

(2) the Drug Formulary Committee must hold a public forum and receive public comment for an additional 15 days from the date of the public forum.

(f) Notwithstanding paragraph (e), the commissioner may automatically require prior authorization for a period not to exceed 180 days for any drug that is approved by the United States Food and Drug Administration after July 1, 2019. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Drug Formulary Committee shall recommend to the commissioner general criteria to use for determining prior authorization of the drugs, but the Drug Formulary Committee is not required to review each individual drug.

(g) The commissioner may also require prior authorization before nonformulary drugs are eligible for payment.

(h) Prior authorization requests must be processed in accordance with Code of Federal Regulations, title 45, section 156.122.

Subd. 3. **Pharmacy provider participation.** (a) A pharmacy enrolled to dispense prescription drugs to medical assistance enrollees under section 256B.0625 must participate as a provider in the MinnesotaCare outpatient prescription drug program.

(b) A pharmacy that is enrolled to dispense prescription drugs to MinnesotaCare enrollees is not permitted to refuse service to an enrollee unless:

(1) the pharmacy does not have a prescription drug in stock and cannot obtain the drug in time to treat the enrollee's medical condition;

(2) the enrollee is unable or unwilling to pay the enrollee's co-payment at the time the drug is dispensed;

(3) after performing drug utilization review, the pharmacist identifies the prescription drug as being a therapeutic duplication, having a drug-disease contraindication, having a drug-drug interaction, having been prescribed for the incorrect dosage or duration of treatment, having a drug-allergy interaction, or having issues related to clinical abuse or misuse by the enrollee;

(4) the prescription drug is not covered by MinnesotaCare; or

(5) dispensing the drug would violate a provision of chapter 151.

Subd. 4. **Covered outpatient prescription drug reimbursement rate.** (a) The basis for determining the amount of payment shall be the lowest of the National Average Drug Acquisition Cost, plus a fixed dispensing fee; the maximum allowable cost established under section 256B.0625, subdivision 13e, plus a fixed dispensing fee; or the usual and customary price. The fixed dispensing fee shall be $1.50 for covered outpatient prescription drugs.

(b) The basis for determining the amount of payment for a pharmacy that acquires drugs through the federal 340B Drug Pricing Program shall be the lowest of:

(1) the National Average Drug Acquisition Cost minus 30 percent;

(2) the maximum allowable cost established under section 256B.0625, subdivision 13e, minus 30 percent, plus a fixed dispensing fee; or

(3) the usual and customary price. The fixed dispensing fee shall be $1.50 for covered outpatient prescription drugs.

(c) For purposes of this subdivision, the usual and customary price is the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes the prices the pharmacy charges to customers enrolled in a prescription savings club or prescription discount club administered by the pharmacy, pharmacy chain, or contractor to the provider.

Subd. 5. **Prescription drug benefit consumer protections.** The prescription drug benefit shall include the protections required under Code of Federal Regulations, title 45, section 156.122, including a standard formulary exception request, expedited exception request, external exception request, and application of coverage appeals laws.

**EFFECTIVE DATE.** This section is effective January 1, 2022.

Sec. 18. **[256T.01] DEFINITIONS.**

Subdivision 1. **Application.** For purposes of this chapter, the terms in this section have the meanings given.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 3. **Department.** "Department" means the Department of Human Services.

Subd. 4. **Essential health benefits.** "Essential health benefits" has the meaning given in section 62Q.81, subdivision 4.

Subd. 5. **Health plan.** "Health plan" has the meaning given in section 62A.011, subdivision 3.

Subd. 6. **Individual market.** "Individual market" has the meaning given in section 62A.011, subdivision 5.

Subd. 7. **MNsure website.** "MNsure website" has the meaning given in section 62V.02, subdivision 13.

Subd. 8. **Qualified health plan.** "Qualified health plan" has the meaning given in section 62A.011, subdivision 7.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 19. **[256T.02] ONECARE BUY-IN.**

Subdivision 1. **Establishment.** (a) The commissioner shall establish a program consistent with this section to offer products developed for the OneCare Buy-In through the MNsure website.

(b) The commissioner, in collaboration with the commissioner of commerce and the MNsure Board, shall:

(1) establish a cost allocation methodology to reimburse MNsure operations in lieu of the premium withhold for qualified health plans under section 62V.05;

(2) implement mechanisms to ensure the long-term financial sustainability of Minnesota's public health care programs and mitigate any adverse financial impacts to the state and MNsure. These mechanisms must minimize adverse selection, state financial risk and contribution, and negative impacts to premiums in the individual and group health insurance markets; and

(3) coordinate eligibility, coverage, and provider networks to ensure that persons, to the extent possible, transitioning between medical assistance, MinnesotaCare, and the OneCare Buy-In have continuity of care.

(c) The OneCare Buy-In shall be considered:

(1) a public health care program for purposes of chapter 62V; and

(2) the MinnesotaCare program for purposes of requirements for health maintenance organizations under section 62D.04, subdivision 5, and providers under section 256B.0644.

(d) The Department of Human Services is deemed to meet and receive certification and authority under section 62D.03 and be in compliance with sections 62D.01 to 62D.30. The commissioner has the authority to accept and expend all federal funds made available under this chapter upon federal approval.

(e) Unless otherwise specified under this chapter, health plans offered under the OneCare Buy-In program must meet all requirements of chapters 62A, 62D, 62K, 62M, 62Q, and 62V determined to be applicable by the regulating authority.

Subd. 2. **Premium administration and payment.** (a) The commissioner shall establish annually a per-enrollee monthly premium rate.

(b) OneCare Buy-In premium administration shall be consistent with requirements under the federal Affordable Care Act for qualified health plan premium administration. Premium rates shall be established in accordance with section 62A.65, subdivision 3.

Subd. 3. **Rates to providers.** The commissioner shall establish rates for provider payments that are targeted to the current rates established under chapter 256L, plus the aggregate difference between those rates and Medicare rates. The aggregate must not consider services that receive a Medicare encounter payment.

Subd. 4. **Reserve and other financial requirements.** (a) A OneCare Buy-In reserve account is established in the state treasury. Enrollee premiums collected under subdivision 2 shall be deposited into the reserve account. The reserve account shall be used to cover expenditures related to operation of the OneCare Buy-In, including the payment of claims and all other accrued liabilities. No other account within the state treasury shall be used to finance the reserve account except as otherwise specified in state law.

(b) Beginning January 1, 2023, enrollee premiums shall be set at a level sufficient to fund all ongoing claims costs and all ongoing costs necessary to manage the program and support ongoing maintenance of information technology systems and operational and administrative functions of the OneCare Buy-In program.

(c) The commissioner is prohibited from expending state dollars beyond what is specifically appropriated in law, or transferring funds from other accounts, in order to fund the reserve account, fund claims costs, or support ongoing administration and operation of the program and its information technology systems.

Subd. 5. **Covered benefits.** Each health plan established under this chapter must include the essential health benefits package required under section 1302(a) of the Affordable Care Act and as described in section 62Q.81; dental services described in section 256B.0625, subdivision 9, paragraphs (b) and (c); and vision services described in Minnesota Rules, part 9505.0277, and may include other services under section 256L.03, subdivision 1.

Subd. 6. **Third-party administrator.** (a) The commissioner may enter into a contract with a third-party administrator to perform the operational management of the OneCare Buy-In. Duties of the third-party administrator include but are not limited to the following:

(1) development and distribution of plan materials for potential enrollees;

(2) receipt and processing of electronic enrollment files sent from the state;

(3) creation and distribution of plan enrollee materials including identification cards, certificates of coverage, a plan formulary, a provider directory, and premium billing statements;

(4) processing premium payments and sending termination notices for nonpayment to enrollees and the state;

(5) payment and adjudication of claims;

(6) utilization management;

(7) coordination of benefits;

(8) grievance and appeals activities; and

(9) fraud, waste, and abuse prevention activities.

(b) Any solicitation of vendors to serve as the third-party administrator is subject to the requirements under section 16C.06.

Subd. 7. **Eligibility.** (a) To be eligible for the OneCare Buy-In, a person must:

(1) be a resident of Minnesota; and

(2) not be enrolled in government-sponsored programs as defined in United States Code, title 26, section 5000A(f)(1)(A). For purposes of this subdivision, an applicant who is enrolled in Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered enrolled in government-sponsored programs. An applicant shall not refuse to apply for or enroll in Medicare coverage to establish eligibility for the OneCare Buy-In.

(b) A person who is determined eligible for enrollment in a qualified health plan with or without advance payments of the premium tax credit and with or without cost-sharing reductions according to Code of Federal Regulations, title 45, section 155.305, paragraphs (a), (f), and (g), is eligible to purchase and enroll in the OneCare Buy-In instead of purchasing a qualified health plan as defined under section 62V.02.

Subd. 8. **Enrollment.** (a) A person may apply for the OneCare Buy-In during the annual open and special enrollment periods established for MNsure as defined in Code of Federal Regulations, title 45, sections 155.410 and 155.420, through the MNsure website.

(b) A person must annually reenroll for the OneCare Buy-In during open and special enrollment periods.

Subd. 9. **Premium tax credits, cost-sharing reductions, and subsidies.** A person who is eligible under this chapter, and whose income is less than or equal to 400 percent of the federal poverty guidelines, may qualify for advance premium tax credits and cost-sharing reductions under Code of Federal Regulations, title 45, section 155.305, paragraphs (a), (f), and (g), to purchase a health plan established under this chapter.

Subd. 10. **Covered benefits and payment rate modifications.** The commissioner, after providing public notice and an opportunity for public comment, may modify the covered benefits and payment rates to carry out this chapter.

Subd. 11. **Provider tax.** Section 295.582, subdivision 1, applies to health plans offered under the OneCare Buy-In program.

Subd. 12. **Request for federal authority.** The commissioner shall seek all necessary federal waivers to establish the OneCare Buy-In under this chapter.

**EFFECTIVE DATE.** (a) Subdivisions 1 to 11 are effective January 1, 2023.

(b) Subdivision 12 is effective the day following final enactment.

Sec. 20. **[256T.03] ONECARE BUY-IN PRODUCTS.**

Subdivision 1. **Platinum product.** The commissioner of human services shall establish a OneCare Buy-In coverage option that provides platinum level of coverage in accordance with the Affordable Care Act and benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the OneCare Buy-In coverage option. This product must be made available in all rating areas in the state.

Subd. 2. **Silver and gold products.** (a) If any rating area lacks an affordable or comprehensive health care coverage option according to standards developed by the commissioner of health, the following year the commissioner of human services shall offer silver and gold products established under paragraph (b) in the rating area for a five-year period.

(b) The commissioner shall establish the following OneCare Buy-In coverage options: one coverage option shall provide silver level of coverage in accordance with the Affordable Care Act and benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the OneCare Buy-In coverage option, and one coverage option shall provide gold level of coverage in accordance with the Affordable Care Act and benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the OneCare Buy-In coverage option.

Subd. 3. **Qualified health plan rules.** (a) The coverage options developed under this section are subject to the process under section 62K.06. The coverage options developed under this section shall meet requirements of chapters 62A, 62K, and 62V that apply to qualified health plans.

(b) The Department of Human Services is not an insurance company for purposes of this chapter.

Subd. 4. **Actuarial value.** Determination of the actuarial value of coverage options under this section must be calculated in accordance with Code of Federal Regulations, title 45, section 156.135.

**EFFECTIVE DATE.** This section is effective January 1, 2023.

Sec. 21. **[256T.04] OUTPATIENT PRESCRIPTION DRUGS.**

Subdivision 1. **Establishment of program.** The commissioner shall administer and oversee the outpatient prescription drug program for the OneCare Buy-In program. The commissioner shall not include the outpatient pharmacy benefit in a contract with a public or private entity.

Subd. 2. **Covered outpatient prescription drugs.** Outpatient prescription drugs are covered in accordance with chapter 256L.

Subd. 3. **Pharmacy provider participation.** Pharmacy provider participation shall be governed by section 256L.30, subdivision 3.

Subd. 4. **Reimbursement rate.** The commissioner shall establish outpatient prescription drug reimbursement rates according to chapter 256L.

Subd. 5. **Prescription drug benefit consumer protections.** Prescription drug benefit consumer protections shall be in accordance with section 256L.30, subdivision 5.

**EFFECTIVE DATE.** This section is effective January 1, 2023.

Sec. 22. Minnesota Statutes 2018, section 270B.12, is amended by adding a subdivision to read:

Subd. 15. **Board of Directors of MNsure.** The commissioner may disclose return information to the extent necessary to the Board of Directors of MNsure to determine eligibility under section 62V.12, subdivision 1.

**EFFECTIVE DATE.** This section is effective for taxable years beginning after December 31, 2020.

Sec. 23. Minnesota Statutes 2018, section 290.0131, is amended by adding a subdivision to read:

Subd. 15. **Health insurance premiums.** The amount of health insurance premiums deducted on the taxpayer's federal return, to the extent used to calculate the credit under section 290.0693, is an addition.

**EFFECTIVE DATE.** This section is effective for taxable years beginning after December 31, 2020.

Sec. 24. **[290.0693] HEALTH INSURANCE PREMIUM CREDIT.**

Subdivision 1. **Credit allowed.** (a) An individual who is a resident of Minnesota is allowed a credit against the tax due under this chapter if the individual would be allowed a credit under section 36B of the Internal Revenue Code, except that the individual's household income, as defined in section 36B(d)(2) of the Internal Revenue Code, exceeds 400 percent of the poverty line for the individual's family size as defined in section 36B(d)(3) of the Internal Revenue Code.

(b) In the determination of "coverage month" under section 36B(c)(2) of the Internal Revenue Code, section 36B(c)(2)(B) and (C) must not apply.

(c) The credit is equal to what the credit would have been under section 36B of the Internal Revenue Code, except the applicable percentage for purposes of section 36B(b)(2)(B)(ii) of the Internal Revenue Code is the highest premium percentage in section 36B(b)(3)(A) of the Internal Revenue Code.

(d) The amount of monthly premiums taken into account under section 36B(b)(2)(A) of the Internal Revenue Code must be reduced by the amount of premium subsidy made by MNsure and applied to the gross premium.

Subd. 2. **Advanced payment of credit.** (a) An individual may claim the credit on the individual's tax return or have the credit paid in advance pursuant to section 62V.12.

(b) If an individual elects to have the credit paid in advance, the credit claimed under subdivision 1 must be reduced by the amount of the advanced payments. If the amount of the advance payments exceeds the amount of credit the individual is eligible for, the tax imposed by this chapter for the taxable year must be increased by the amount of the excess.

(c) If the amount of credit that the individual is allowed under subdivision 1, after subtracting any advanced payments, exceeds the individual's tax liability under this chapter, the commissioner shall refund the excess to the individual.

(d) By January 31 of each year, the Board of Directors of MNsure must provide to each individual who applied for assistance and enrolled in a qualified health plan and to the commissioner a statement containing information on the preceding year necessary to reconcile the credit with the advance payments. The Board of Directors of MNsure and the commissioner must consult to develop the form and manner of the report.

(e) Each year, 60 days prior to MNsure's open enrollment, the commissioner shall provide information to MNsure about which individuals received an advanced payment of the state-based health insurance tax credit under section 62V.12 in a prior taxable year and did not file a return and reconcile the payments for that taxable year.

Subd. 3. **Reporting requirements.** (a) If the individual has a change in eligibility status determination by MNsure, after the taxable year is complete, the individual and MNsure must notify the commissioner of the change in eligibility within six months of the change.

(b) Notwithstanding any law to the contrary, the commissioner may recompute the tax due based on the determination of eligibility.

Subd. 4. **Appropriation.** (a) An amount sufficient to pay the refunds required by this section is appropriated to the commissioner from the health care access fund.

(b) $1,037,000 in fiscal year 2022 and $880,000 in each fiscal year thereafter are the base from the health care access fund to the commissioner of revenue for administering this section.

**EFFECTIVE DATE.** This section is effective for taxable years beginning after December 31, 2020.

Sec. 25. Minnesota Statutes 2018, section 295.51, subdivision 1a, is amended to read:

Subd. 1a. **Nexus in Minnesota.** (a) To the extent allowed by the United States Constitution and the laws of the United States, a person who is a wholesale drug distributor ~~has nexus in Minnesota if its contacts with or presence in Minnesota is sufficient to satisfy the requirements of the United States Constitution.~~, a person who receives legend drugs for resale or use in Minnesota other than from a wholesale drug distributor that is subject to tax, or a person who sells or repairs hearing aids and related equipment or prescription eyewear is subject to the taxes imposed by this chapter if the person:

(1) has or maintains within this state, directly or by a subsidiary or an affiliate, an office, place of distribution, sales, storage, or sample room or place, warehouse, or other place of business, including the employment of a resident of this state who works from a home office in this state;

(2) has a representative, including but not limited to an employee, affiliate, agent, salesperson, canvasser, solicitor, independent contractor, or other third party operating in this state under the person's authority or the authority of the person's subsidiary, for any purpose, including the repairing, selling, delivering, installing, facilitating sales, processing sales, or soliciting of orders for the person's goods or services, or the leasing of tangible personal property located in this state, whether the place of business or the agent, representative, affiliate, salesperson, canvasser, or solicitor is located in the state permanently or temporarily, or whether or not the person, subsidiary, or affiliate is authorized to do business in this state;

(3) owns or leases real property that is located in this state; or

(4) owns or leases tangible personal property that is present in this state, including but not limited to mobile property.

(b) To the extent allowed by the United States Constitution and the laws of the United States, a person who is a wholesale drug distributor, or a person who receives legend drugs for resale or use in Minnesota other than from a wholesale drug distributor that is subject to tax, is subject to the taxes imposed by this chapter if the person:

(1) conducts a trade or business not described in paragraph (a) and sells, delivers, or distributes legend drugs from outside this state to a destination within this state by common carrier or otherwise; and

(2) meets one of the following thresholds:

(i) makes 100 or more sales, deliveries, or distributions described in clause (1) during any taxable year;

(ii) the gross revenues of a wholesale drug distributor that sells or distributes legend drugs as described in clause (1) totals more than $100,000 during any taxable year; or

(iii) the price paid by a person who receives legend drugs for resale or use in Minnesota other than from a wholesale drug distributor that is subject to tax for legend drugs as described in clause (1) totals more than $100,000 during any taxable year.

(c) To the extent allowed by the United States Constitution and the laws of the United States, a person who sells or repairs hearing aids and related equipment or prescription eyewear is subject to the taxes imposed by this chapter if the person:

(1) conducts a trade or business not described in paragraph (a) and:

(i) sells, delivers, or distributes hearing aids or prescription eyewear from outside of this state to a destination within this state by common carrier or otherwise; or

(ii) repairs hearing aids or prescription eyewear outside of this state and delivers or distributes the hearing aids or prescription eyewear to a destination within this state by common carrier or otherwise; and

(2) meets one of the following thresholds:

(i) makes 100 or more sales, deliveries, distributions, or repairs described in clause (1) during any taxable year; or

(ii) the gross revenues of the person who sells, delivers, distributes, or repairs hearing aids or prescription eyewear described in clause (1) totals more than $100,000 during any taxable year.

(d) Once a taxpayer has established nexus with Minnesota under paragraph (b) or (c), the taxpayer must continue to file an annual return and remit taxes for subsequent years. A taxpayer who has established nexus under paragraph (b) or (c) is no longer required to file an annual return and remit taxes if the taxpayer:

(1) ceases to engage in the activities, or no longer meets any of the applicable thresholds, in paragraph (b) or (c) for an entire taxable year; and

(2) notifies the commissioner by March 15 of the following calendar year, in a manner prescribed by the commissioner, that the taxpayer no longer engages in any of the activities, or no longer meets any of the applicable thresholds, in paragraph (b) or (c).

(e) If, after notifying the commissioner pursuant to paragraph (d), the taxpayer subsequently engages in any of the activities, and meets any of the applicable thresholds, in paragraph (b) or (c), the taxpayer shall again comply with the applicable requirements of paragraphs (b), (c), and (d).

**EFFECTIVE DATE; APPLICATION.** (a) This section is effective the day following final enactment.

(b) In enacting this section, the legislature confirms that the United States Supreme Court decision in South Dakota v. Wayfair, Inc. et al., Dkt. No. 17-494 (June 21, 2018); 138 S. Ct. 2080 (2018), applied upon the date of that decision to provide Minnesota with jurisdiction over persons described in paragraphs (b) and (c) for purposes of imposing tax under chapter 295 to the extent allowed by the United States Constitution and the laws of the United States.

Sec. 26. Minnesota Statutes 2018, section 295.57, subdivision 3, is amended to read:

Subd. 3. **Interest on overpayments.** Interest must be paid on an overpayment refunded or credited to the taxpayer ~~from the date of payment of the tax until the date the refund is paid or credited. For purposes of this subdivision, the date of payment is the due date of the return or the date of actual payment of the tax, whichever is later~~ in the manner provided in section 289A.56, subdivision 2.

**EFFECTIVE DATE.** This section is effective for overpayments made on or after January 1, 2020.

Sec. 27. Minnesota Statutes 2018, section 295.582, subdivision 1, is amended to read:

Subdivision 1. **Tax expense transfer.** (a) A hospital, surgical center, or health care provider that is subject to a tax under section 295.52, or a pharmacy that has paid additional expense transferred under this section by a wholesale drug distributor, may transfer additional expense generated by section 295.52 obligations on to all third-party contracts for the purchase of health care services on behalf of a patient or consumer. Nothing shall prohibit a pharmacy from transferring the additional expense generated under section 295.52 to a pharmacy benefits manager. The additional expense transferred to the third-party purchaser or a pharmacy benefits manager must not exceed the tax percentage specified in section 295.52 multiplied against the gross revenues received under the third-party contract, and the tax percentage specified in section 295.52 multiplied against co-payments and deductibles paid by the individual patient or consumer. The expense must not be generated on revenues derived from payments that are excluded from the tax under section 295.53. All third-party purchasers of health care services including, but not limited to, third-party purchasers regulated under chapter 60A, 62A, 62C, 62D, 62H, 62N, 64B, 65A, 65B, 79, ~~or~~ 79A, or 256T, or under section 471.61 or 471.617, and pharmacy benefits managers must pay the transferred expense in addition to any payments due under existing contracts with the hospital, surgical center, pharmacy, or health care provider, to the extent allowed under federal law. A third-party purchaser of health care services includes, but is not limited to, a health carrier or community integrated service network that pays for health care services on behalf of patients or that reimburses, indemnifies, compensates, or otherwise insures patients for health care services. For purposes of this section, a pharmacy benefits manager means an entity that performs pharmacy benefits management. A third-party purchaser or pharmacy benefits manager shall comply with this section regardless of whether the third-party purchaser or pharmacy benefits manager is a for-profit, not-for-profit, or nonprofit entity. A wholesale drug distributor may transfer additional expense generated by section

295.52 obligations to entities that purchase from the wholesaler, and the entities must pay the additional expense. Nothing in this section limits the ability of a hospital, surgical center, pharmacy, wholesale drug distributor, or health care provider to recover all or part of the section 295.52 obligation by other methods, including increasing fees or charges.

(b) Any hospital, surgical center, or health care provider subject to a tax under section 295.52 or a pharmacy that has paid additional expense transferred under this section by a wholesale drug distributor may file a complaint with the commissioner responsible for regulating the third-party purchaser if at any time the third-party purchaser fails to comply with paragraph (a).

(c) If the commissioner responsible for regulating the third-party purchaser finds at any time that the third-party purchaser has not complied with paragraph (a), the commissioner may take enforcement action against a third-party purchaser which is subject to the commissioner's regulatory jurisdiction and which does not allow a hospital, surgical center, pharmacy, or provider to pass-through the tax. The commissioner may by order fine or censure the third-party purchaser or revoke or suspend the certificate of authority or license of the third-party purchaser to do business in this state if the commissioner finds that the third-party purchaser has not complied with this section. The third-party purchaser may appeal the commissioner's order through a contested case hearing in accordance with chapter 14.

Sec. 28. **DIRECTION TO COMMISSIONER; STATE-BASED RISK ADJUSTMENT ANALYSIS.**

The commissioner of commerce, in consultation with the commissioner of health, shall conduct a study on the design and implementation of a state-based risk adjustment program. The commissioner shall report on the findings of the study and any recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over the individual health insurance market by February 15, 2021.

Sec. 29. **STUDY OF COST OF PROVIDING DENTAL SERVICES.**

The commissioner of human services shall contract with a vendor to conduct a survey of the cost to Minnesota dental providers of delivering dental services to medical assistance and MinnesotaCare enrollees under both fee-for-service and managed care. The commissioner of human services shall ensure that the vendor has prior experience in conducting surveys of the cost of providing health care services. Each dental provider enrolled with the department must respond to the cost of service survey. The commissioner of human services

may sanction a dental provider under Minnesota Statutes, section 256B.064, for failure to respond. The commissioner of human services shall require the vendor to measure statewide and regional costs for both fee-for-service and managed care, by major dental service category and for the most common dental services. The commissioner of human services shall post a copy of the final survey report on the department's website. The initial survey must be completed no later than January 1, 2021, and the survey must be repeated every three years. The commissioner of human services shall provide a summary of the results of each cost of dental services survey and provide recommendations for any changes to dental payment rates to the chairs and ranking members of the legislative committees with jurisdiction over health and human services policy and finance.

Sec. 30. **OUTPATIENT PHARMACY BENEFIT FOR ENROLLEES OF HEALTH PLAN COMPANIES.**

(a) The commissioner of human services shall develop a plan for an outpatient pharmacy benefit to be administered by the commissioner of human services for enrollees of health plan companies. The plan must:

(1) provide prescription drug coverage, beginning January 1, 2022, to the enrollees of health plan companies that choose to participate in the pharmacy benefit program;

(2) provide coverage and reimbursement for outpatient prescription drugs in accordance with Minnesota Statutes, chapter 256L;

(3) require the commissioner to annually determine and publish the monthly premium per enrollee for prescription drug coverage by August 1 of each year, for coverage taking effect the following January 1;

(4) establish different co-payments for each of the following categories: preferred generic drugs; preferred branded drugs; nonpreferred generic drugs; nonpreferred branded drugs; and specialty drugs; and

(5) require a health plan company that enters into a contract with the commissioner to participate in the program to pay the commissioner for all costs incurred in providing a prescription drug benefit, including costs related to benefit administration and the purchasing of prescription drugs.

(b) The commissioner shall present the plan to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance and health insurance by December 15, 2019.

Sec. 31. **BENEFIT AND COST ANALYSIS OF A UNIFIED HEALTH CARE FINANCING SYSTEM.**

Subdivision 1. **Contract for analysis of proposal.** The commissioner of health shall contract with the University of Minnesota School of Public Health to conduct an analysis of the current health care financing environment and evaluate whether a unified health care financing system would provide better access to care, reduce or slow the rate of increase in total health care spending, and provide other benefits to individuals, businesses, and the state economy, relative to the current health care financing environment.

Subd. 2. **Proposal.** The analysis shall include recommendations for a framework for a unified health care financing system designed to:

(1) ensure all Minnesotans have access to all necessary primary and specialty care, including dental, vision and hearing, mental health, chemical dependency treatment, prescription drugs, medical equipment and supplies, long-term, and home care;

(2) maximize the ability for patients to choose doctors, hospitals, and other providers; and

(3) incentivize a focus on preventative care and public health, including social determinants of health and care coordination.

Subd. 3. **Proposal analysis.** (a) The analysis must forecast over a ten-year or longer period determined to be sufficient to capture all benefits and costs of the unified health care financing system. The analysis must compare and contrast the impact of the proposed health care financing system and the current health care financing environment on:

(1) the number of people covered versus the number of people who continue to lack access to health care because of financial or other barriers, if any;

(2) the completeness of the coverage and the number of people lacking coverage for dental, long-term care, medical equipment or supplies, vision and hearing, or other health services that are not covered, if any;

(3) the adequacy of the coverage, the level of underinsured in the state, and whether people with coverage can afford the care they need or whether cost prevents them from accessing care;

(4) the timeliness and appropriateness of the care received and whether people turn to less appropriate care such as emergency rooms because of a lack of proper care in accordance with clinical guidelines; and

(5) total public and private health care spending in Minnesota under the current health care financing environment versus a unified health care financing system, including all spending by individuals, businesses, and government. "Total public and private health care spending" means spending on all medical care including but not limited to dental, vision and hearing, mental health, chemical dependency treatment, prescription drugs, medical equipment and supplies, long-term care, and home care, whether paid through premiums, co-pays and deductibles, other out-of-pocket payments, or other funding from government, employers, or other sources. Total public and private health care spending also includes the costs associated with administering, delivering, and paying for the care. The costs of administering, delivering, and paying for the care includes all expenses by insurers, providers, employers, individuals, and government to select, negotiate, purchase, and administer insurance and care including but not limited to coverage for health care, dental, prescription drugs, medical expense portions of workers compensation and automobile insurance, and the cost of administering and paying for all health care products and services that are not covered by insurance. The analysis of total health care spending shall examine, to the extent possible given available data and resources, whether there are savings or additional costs under the proposed health care financing system compared to the existing health care financing environment due to:

(i) reduced insurance, billing, underwriting, marketing, evaluation, and other administrative functions including savings from global budgeting for hospitals and institutional care instead of billing for individual services provided;

(ii) reduced prices on medical services and products including pharmaceuticals due to price negotiations, if applicable under the proposal;

(iii) shortages or excess capacity of medical facilities and equipment;

(iv) changes in utilization, better health outcomes, and reduced time away from work due to prevention, early intervention, and health-promoting activities; and

(v) the impact on state, local, and federal government non-health-care expenditures, such as reduced demand for public services and reduced out-of-home placement costs due to increased access to mental health and chemical dependency services.

(b) The analysis shall assume that operation of the unified health care financing system is not preempted by federal law.

(c) The commissioner shall issue a final report by January 15, 2021, and may provide interim reports and status updates to the governor and the chairs and ranking minority

members of the legislative committees with jurisdiction over health and human services policy and finance.

Sec. 32. **RATE CHANGES AND DENTAL ACCESS.**

The commissioner of human services, in consultation with stakeholders, including the Health Services Policy Committee established in Minnesota Statutes, section 256B.0625, subdivision 3c, shall analyze the impact of the dental rate changes in this article that take effect January 1, 2022, to evaluate the impact on access to dental services for medical assistance and MinnesotaCare program participants. The analysis may recommend changes to payment methodologies. In evaluating access, the analysis shall at a minimum consider distance traveled by enrollees, access to regular and urgent dental care, and the availability of a dental home. The analysis shall consider the impact of any changes on the providers currently enrolled in the medical assistance and MinnesotaCare programs as well as the potential impact on providers who currently do not participate. Any changes to payment methodologies recommended as part of this analysis must include a comprehensive, uniform rate for the provision of dental services for all recipients of medical assistance and MinnesotaCare, prioritizing access to both preventative and restorative dental services among children under age 21. The commissioner shall provide, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, a preliminary report on the results of the analysis by December 1, 2019, and a final report and any recommendations by December 1, 2020.

Sec. 33. **REPEALER.**

Minnesota Statutes 2018, section 256L.11, subdivision 6a, is repealed.

**EFFECTIVE DATE.** This section is effective January 1, 2022.

## ARTICLE 10
## PRESCRIPTION DRUGS

Section 1. Minnesota Statutes 2018, section 8.31, subdivision 1, is amended to read:

Subdivision 1. **Investigate offenses against provisions of certain designated sections; assist in enforcement.** The attorney general shall investigate violations of the law of this state respecting unfair, discriminatory, and other unlawful practices in business, commerce, or trade, and specifically, but not exclusively, the Prohibition Against Charging Unconscionable Prices for Prescription Drugs (section 151.462), the Nonprofit Corporation Act (sections 317A.001 to 317A.909), the Act Against Unfair Discrimination and

Competition (sections 325D.01 to 325D.07), the Unlawful Trade Practices Act (sections 325D.09 to 325D.16), the Antitrust Act (sections 325D.49 to 325D.66), section 325F.67 and other laws against false or fraudulent advertising, the antidiscrimination acts contained in section 325D.67, the act against monopolization of food products (section 325D.68), the act regulating telephone advertising services (section 325E.39), the Prevention of Consumer Fraud Act (sections 325F.68 to 325F.70), and chapter 53A regulating currency exchanges and assist in the enforcement of those laws as in this section provided.

Sec. 2. Minnesota Statutes 2018, section 62J.23, subdivision 2, is amended to read:

Subd. 2. **Restrictions.** (a) From July 1, 1992, until rules are adopted by the commissioner under this section, the restrictions in the federal Medicare antikickback statutes in section 1128B(b) of the Social Security Act, United States Code, title 42, section 1320a-7b(b), and rules adopted under the federal statutes, apply to all persons in the state, regardless of whether the person participates in any state health care program.

(b) Nothing in paragraph (a) shall be construed to prohibit an individual from receiving a discount or other reduction in price or a limited-time free supply or samples of a prescription drug, medical supply, or medical equipment offered by a pharmaceutical manufacturer, medical supply or device manufacturer, health plan company, or pharmacy benefit manager, so long as:

(1) the discount or reduction in price is provided to the individual in connection with the purchase of a prescription drug, medical supply, or medical equipment prescribed for that individual;

(2) it otherwise complies with the requirements of state and federal law applicable to enrollees of state and federal public health care programs;

(3) the discount or reduction in price does not exceed the amount paid directly by the individual for the prescription drug, medical supply, or medical equipment; and

(4) the limited-time free supply or samples are provided by a physician or pharmacist, as provided by the federal Prescription Drug Marketing Act.

<u>For purposes of this paragraph, "prescription drug" includes prescription drugs that are administered through infusion, and related services and supplies.</u>

(c) No benefit, reward, remuneration, or incentive for continued product use may be provided to an individual or an individual's family by a pharmaceutical manufacturer, medical supply or device manufacturer, or pharmacy benefit manager, except that this prohibition does not apply to:

(1) activities permitted under paragraph (b);

(2) a pharmaceutical manufacturer, medical supply or device manufacturer, health plan company, or pharmacy benefit manager providing to a patient, at a discount or reduced price or free of charge, ancillary products necessary for treatment of the medical condition for which the prescription drug, medical supply, or medical equipment was prescribed or provided; and

(3) a pharmaceutical manufacturer, medical supply or device manufacturer, health plan company, or pharmacy benefit manager providing to a patient a trinket or memento of insignificant value.

(d) Nothing in this subdivision shall be construed to prohibit a health plan company from offering a tiered formulary with different co-payment or cost-sharing amounts for different drugs.

Sec. 3. **[62Q.528] DRUG COVERAGE IN EMERGENCY SITUATIONS.**

A health plan that provides prescription drug coverage must provide coverage for a prescription drug dispensed by a pharmacist under section 151.211, subdivision 3, under the terms of coverage that would apply had the prescription drug been dispensed according to a prescription.

Sec. 4. **[62Q.83] PRESCRIPTIONS FOR SPECIALTY DRUGS.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meaning given them.

(b) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, but also includes a county-based purchasing plan participating in a public program under chapter 256B or 256L, and in integrated health partnership under section 256B.0755.

(c) "Mail order pharmacy" means a pharmacy whose primary business is to receive prescriptions by mail, fax, or through electronic submissions, dispense prescription drugs to enrollees through the use of United States mail or other common carrier services, and provide consultation with patients by telephone or electronically rather than face-to-face.

(d) "Pharmacy benefit manager" has the meaning provided in section 151.71, subdivision 1, paragraph (c).

(e) "Retail pharmacy" means a chain pharmacy, a supermarket pharmacy, an independent pharmacy, or a network of independent pharmacies, licensed under chapter 151, that dispenses prescription drugs to the public.

(f) "Specialty drug" means a prescription drug that:

(1) is not routinely made available to enrollees of a health plan company or its contracted pharmacy benefit manager through dispensing by a retail pharmacy, regardless if the drug is meant to be self-administered;

(2) must usually be obtained from specialty or mail order pharmacies; and

(3) has special storage, handling, or distribution requirements that typically cannot be met by a retail pharmacy.

Subd. 2. **Prompt filling of specialty drug prescriptions.** A health plan company or its contracted pharmacy benefit manager that requires or provides financial incentives for enrollees to use a mail order pharmacy to fill a prescription for a specialty drug must ensure through contract and other means that the mail order pharmacy dispenses the prescription drug to the enrollee in a timely manner, such that the enrollee receives the filled prescription within five business days of the date of transmittal to the mail order pharmacy. The health plan company or contracted pharmacy benefit manager may grant an exemption from this requirement if the mail order pharmacy can document that the specialty drug was out of stock due to a delay in shipment by the specialty drug manufacturer or prescription drug wholesaler. If an exemption is granted, the health plan company or pharmacy benefit manager shall notify the enrollee within 24 hours of granting the exemption and, if medically necessary, shall provide the enrollee with an emergency supply of the specialty drug.

**EFFECTIVE DATE.** This section is effective January 1, 2020, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 5. **[62Q.84] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND MANAGEMENT.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "Drug" has the meaning given in section 151.01, subdivision 5.

(c) "Enrollee contract term" means the 12-month term during which benefits associated with health plan company products are in effect. For managed care plans and county-based purchasing plans under section 256B.69 and chapter 256L, it means a single calendar quarter.

(d) "Formulary" means a list of prescription drugs that have been developed by clinical and pharmacy experts and represents the health plan company's medically appropriate and cost-effective prescription drugs approved for use.

(e) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, and includes an entity that performs pharmacy benefits management for the health plan company. For purposes of this definition, "pharmacy benefits management" means the administration or management of prescription drug benefits provided by the health plan company for the benefit of its enrollees and may include but is not limited to procurement of prescription drugs, clinical formulary development and management services, claims processing, and rebate contracting and administration.

(f) "Prescription" has the meaning given in section 151.01, subdivision 16a.

Subd. 2. **Prescription drug benefit disclosure.** (a) A health plan company that provides prescription drug benefit coverage and uses a formulary must make its formulary and related benefit information available by electronic means and, upon request, in writing, at least 30 days prior to annual renewal dates.

(b) Formularies must be organized and disclosed consistent with the most recent version of the United States Pharmacopeia's (USP) Model Guidelines.

(c) For each item or category of items on the formulary, the specific enrollee benefit terms must be identified, including enrollee cost-sharing and expected out-of-pocket costs.

Subd. 3. **Formulary changes.** (a) Once a formulary has been established, a health plan company may, at any time during the enrollee's contract term:

(1) expand its formulary by adding drugs to the formulary;

(2) reduce co-payments or coinsurance; or

(3) move a drug to a benefit category that reduces an enrollee's cost.

(b) A health plan company may remove a brand name drug from its formulary or place a brand name drug in a benefit category that increases an enrollee's cost only upon the addition to the formulary of a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book or a biologic drug rated as interchangeable according to the FDA Purple Book at a lower cost to the enrollee, and upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

(c) A health plan company may change utilization review requirements or move drugs to a benefit category that increases an enrollee's cost during the enrollee's contract term

upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees, provided that these changes do not apply to enrollees who are currently taking the drugs affected by these changes for the duration of the enrollee's contract term.

(d) A health plan company may remove any drugs from its formulary that have been deemed unsafe by the Food and Drug Administration, that have been withdrawn by either the Food and Drug Administration or the product manufacturer, or when an independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes in drug usage.

Sec. 6. **[62W.01] CITATION.**

This chapter may be cited as the "Minnesota Pharmacy Benefit Manager Licensure and Regulation Act."

Sec. 7. **[62W.02] DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of this chapter, the following terms have the meanings given.

Subd. 2. **Aggregate retained rebate.** "Aggregate retained rebate" means the percentage of all rebates received by a pharmacy benefit manager from a drug manufacturer for drug utilization that is not passed on to the pharmacy benefit manager's health carrier's clients.

Subd. 3. **Claims processing service.** "Claims processing service" means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacy services that includes:

(1) receiving payments for pharmacy services;

(2) making payments to pharmacists or pharmacies for pharmacy services; or

(3) both clause (1) and clause (2).

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 5. **Enrollee.** "Enrollee" means a natural person covered by a health plan and includes an insured, policyholder, subscriber, contract holder, member, covered person, or certificate holder.

Subd. 6. **Health carrier.** "Health carrier" has the meaning given in section 62A.011, subdivision 2.

Subd. 7. **Health plan.** "Health plan" means a policy, contract, certificate, or agreement defined in section 62A.011, subdivision 3.

Subd. 8. **Mail order pharmacy.** "Mail order pharmacy" means a pharmacy whose primary business is to receive prescriptions by mail, fax, or through electronic submissions, dispense prescription drugs to enrollees through the use of the United States mail or other common carrier services, and provide consultation with patients electronically rather than face-to-face.

Subd. 9. **Maximum allowable cost price.** "Maximum allowable cost price" means the maximum amount that a pharmacy benefit manager will reimburse a pharmacy for a group of therapeutically and pharmaceutically equivalent multiple source drugs. The maximum allowable cost price does not include a dispensing or professional fee.

Subd. 10. **Multiple source drugs.** "Multiple source drugs" means a therapeutically equivalent drug that is available from at least two manufacturers.

Subd. 11. **Network pharmacy.** "Network pharmacy" means a retail or other licensed pharmacy provider that directly contracts with a pharmacy benefit manager.

Subd. 12. **Other prescription drug or device services.** "Other prescription drug or device services" means services other than claims processing services, provided directly or indirectly, whether in connection with or separate from claims processing services, including:

(1) negotiating rebates, discounts, or other financial incentives and arrangements with drug manufacturers;

(2) disbursing or distributing rebates;

(3) managing or participating in incentive programs or arrangements for pharmacy services;

(4) negotiating or entering into contractual arrangements with pharmacists or pharmacies, or both;

(5) developing prescription drug formularies;

(6) designing prescription benefit programs; or

(7) advertising or promoting services.

Subd. 13. **Pharmacist.** "Pharmacist" means an individual with a valid license issued by the Board of Pharmacy under chapter 151.

Subd. 14. **Pharmacy.** "Pharmacy" or "pharmacy provider" means a place of business licensed by the Board of Pharmacy under chapter 151 in which prescription drugs are prepared, compounded, or dispensed, or under the supervision of a pharmacist.

Subd. 15. **Pharmacy benefit manager.** (a) "Pharmacy benefit manager" means a person, business, or other entity that contracts with a plan sponsor to perform pharmacy benefits management, including but not limited to:

(1) contracting directly or indirectly with pharmacies to provide prescription drugs to enrollees or other covered individuals;

(2) administering a prescription drug benefit;

(3) processing or paying pharmacy claims;

(4) creating or updating prescription drug formularies;

(5) making or assisting in making prior authorization determinations on prescription drugs;

(6) administering rebates on prescription drugs; or

(7) establishing a pharmacy network.

(b) "Pharmacy benefit manager" does not include the Department of Human Services.

Subd. 16. **Plan sponsor.** "Plan sponsor" means a group purchaser as defined under section 62J.03; an employer in the case of an employee health benefit plan established or maintained by a single employer; or an employee organization in the case of a health plan established or maintained by an employee organization, an association, joint board trustees, a committee, or other similar group that establishes or maintains the health plan. This term includes a person or entity acting for a pharmacy benefit manager in a contractual or employment relationship in the performance of pharmacy benefits management. Plan sponsor does not include the Department of Human Services.

Subd. 17. **Specialty drug.** "Specialty drug" means a prescription drug that:

(1) cannot be routinely dispensed at a majority of retail pharmacies;

(2) is used to treat chronic and complex, or rare, medical conditions; and

(3) meets a majority of the following criteria:

(i) requires special handling or storage;

(ii) requires complex and extended patient education or counseling;

(iii) requires intensive monitoring;

(iv) requires clinical oversight; and

(v) requires product support services.

Subd. 18. **Retail pharmacy.** "Retail pharmacy" means a chain pharmacy, a supermarket pharmacy, an independent pharmacy, or a network of independent pharmacies, licensed under chapter 151, that dispenses prescription drugs to the public.

Subd. 19. **Rebates.** "Rebates" means all price concessions paid by a drug manufacturer to a pharmacy benefit manager or plan sponsor, including discounts and other price concessions that are based on the actual or estimated utilization of a prescription drug. Rebates also include price concessions based on the effectiveness of a prescription drug as in a value-based or performance-based contract.

Sec. 8. **[62W.03] LICENSE TO DO BUSINESS.**

Subdivision 1. **General.** (a) Beginning January 1, 2020, no person shall perform, act, or do business in this state as a pharmacy benefits manager unless the person has a valid license issued under this chapter by the commissioner of commerce.

(b) A license issued in accordance with this chapter is nontransferable.

Subd. 2. **Application.** (a) A pharmacy benefit manager seeking a license shall apply to the commissioner of commerce on a form prescribed by the commissioner. The application form must include at a minimum the following information:

(1) the name, address, and telephone number of the pharmacy benefit manager;

(2) the name and address of the pharmacy benefit manager agent for service of process in this state;

(3) the name, address, official position, and professional qualifications of each person responsible for the conduct of affairs of the pharmacy benefit manager, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee; the principal officers in the case of a corporation; or the partners or members in the case of a partnership or association; and

(4) a statement reasonably describing the geographic area or areas to be served and the type or types of enrollees to be served.

(b) Each application for licensure must be accompanied by a nonrefundable fee of $8,500 and evidence of financial responsibility in the amount of $1,000,000 to be maintained at all

times by the pharmacy benefit manager during its licensure period. The fees collected under this subdivision shall be deposited in the general fund.

(c) Within 30 days of receiving an application, the commissioner may require additional information or submissions from an applicant and may obtain any document or information reasonably necessary to verify the information contained in the application. Within 90 days after receipt of a completed application, evidence of financial responsibility, the network adequacy report required under section 62W.05, and the applicable license fee, the commissioner shall review the application and issue a license if the applicant is deemed qualified under this section. If the commissioner determines the applicant is not qualified, the commissioner shall notify the applicant and shall specify the reason or reasons for the denial.

Subd. 3. **Renewal.** (a) A license issued under this chapter is valid for a period of one year. To renew a license, an applicant must submit a completed renewal application on a form prescribed by the commissioner, the network adequacy report required under section 62W.05, and a renewal fee of $8,500. The commissioner may request a renewal applicant to submit additional information to clarify any new information presented in the renewal application. The fees collected under this paragraph shall be deposited in the general fund.

(b) A renewal application submitted after the renewal deadline date must be accompanied by a nonrefundable late fee of $500. The fees collected under this paragraph shall be deposited in the general fund.

(c) The commissioner shall deny the renewal of a license for any of the following reasons:

(1) the pharmacy benefit manager is operating in a financially hazardous condition relative to its financial condition and the services it administers for health carriers;

(2) the pharmacy benefit manager has been determined by the commissioner to be in violation or noncompliance with the requirements of state law or the rules promulgated under this chapter; or

(3) the pharmacy benefit manager has failed to timely submit a renewal application and the information required under paragraph (a).

In lieu of a denial of a renewal application, the commissioner may permit the pharmacy benefit manager to submit to the commissioner a corrective action plan to cure or correct deficiencies.

Subd. 4. **Oversight.** (a) The commissioner may suspend, revoke, or place on probation a pharmacy benefit manager license issued under this chapter for any of the following circumstances:

(1) the pharmacy benefit manager has engaged in fraudulent activity that constitutes a violation of state or federal law;

(2) the commissioner has received consumer complaints that justify an action under this subdivision to protect the safety and interests of consumers;

(3) the pharmacy benefit manager fails to pay an application license or renewal fee; and

(4) the pharmacy benefit manager fails to comply with a requirement set forth in this chapter.

(b) The commissioner may issue a license subject to restrictions or limitations, including the types of services that may be supplied or the activities in which the pharmacy benefit manager may be engaged.

Subd. 5. **Penalty.** If a pharmacy benefit manager acts without a license, the pharmacy benefit manager may be subject to a fine of $5,000 per day for the period the pharmacy benefit manager is found to be in violation. Any penalties collected under this subdivision shall be deposited in the general fund.

Subd. 6. **Rulemaking.** The commissioner may adopt rules to implement this section.

Subd. 7. **Enforcement.** The commissioner shall enforce this chapter under the provisions of chapter 45.

Sec. 9. **[62W.04] PHARMACY BENEFIT MANAGER GENERAL BUSINESS PRACTICES.**

(a) A pharmacy benefit manager has a fiduciary duty to a health carrier and must discharge that duty in accordance with the provisions of state and federal law.

(b) A pharmacy benefit manager must perform its duties with care, skill, prudence, diligence, and professionalism. A pharmacy benefit manager must exercise good faith and fair dealing in the performance of its contractual duties. A provision in a contract between a pharmacy benefit manager and a health carrier or a network pharmacy that attempts to waive or limit this obligation is void.

(c) A pharmacy benefit manager must notify a health carrier in writing of any activity, policy, or practice of the pharmacy benefit manager that directly or indirectly presents a conflict of interest with the duties imposed in this section.

Sec. 10. **[62W.05] PHARMACY BENEFIT MANAGER NETWORK ADEQUACY.**

(a) A pharmacy benefit manager must provide an adequate and accessible pharmacy network for the provision of prescription drugs as defined under section 62K.10. Mail order pharmacies must not be included in the calculations of determining the adequacy of the pharmacy benefit manager's pharmacy network under section 62K.10.

(b) A pharmacy benefit manager must submit to the commissioner a pharmacy network adequacy report describing the pharmacy network and pharmacy accessibility in this state, with the pharmacy benefit manager's license application and renewal, in a manner prescribed by the commissioner.

(c) A pharmacy benefit manager may apply for a waiver of the requirements in paragraph (a) if it is unable to meet the statutory requirements. A waiver application must be submitted on a form provided by the commissioner and must (1) demonstrate with specific data that the requirement of paragraph (a) is not feasible in a particular service area or part of a service area, and (2) include information as to the steps that were and will be taken to address the network inadequacy. The waiver shall automatically expire after three years. If a renewal of the waiver is sought, the commissioner shall take into consideration steps that have been taken to address network adequacy.

(d) The pharmacy benefit manager must establish a pharmacy network service area consistent with the requirements under section 62K.13 for every pharmacy network subject to review under this section.

Sec. 11. **[62W.06] PHARMACY BENEFIT MANAGER TRANSPARENCY.**

Subdivision 1. **Transparency to plan sponsors.** (a) Beginning in the second quarter after the effective date of a contract between a pharmacy benefit manager and a plan sponsor, the pharmacy benefit manager must disclose, upon the request of the plan sponsor, the following information with respect to prescription drug benefits specific to the plan sponsor:

(1) the aggregate wholesale acquisition costs from a drug manufacturer or wholesale drug distributor for each therapeutic category of prescription drugs;

(2) the aggregate amount of rebates received by the pharmacy benefit manager by therapeutic category of prescription drugs. The aggregate amount of rebates must include any utilization discounts the pharmacy benefit manager receives from a drug manufacturer or wholesale drug distributor;

(3) any other fees received from a drug manufacturer or wholesale drug distributor;

(4) whether the pharmacy benefit manager has a contract, agreement, or other arrangement with a drug manufacturer to exclusively dispense or provide a drug to a plan sponsor's employees or enrollees, and the application of all consideration or economic benefits collected or received pursuant to the arrangement;

(5) prescription drug utilization information for the plan sponsor's employees or enrollees that is not specific to any individual employee or enrollee;

(6) de-identified claims level information in electronic format that allows the plan sponsor to sort and analyze the following information for each claim:

(i) the drug and quantity for each prescription;

(ii) whether the claim required prior authorization;

(iii) patient cost-sharing paid on each prescription;

(iv) the amount paid to the pharmacy for each prescription, net of the aggregate amount of fees or other assessments imposed on the pharmacy, including point-of-sale and retroactive charges;

(v) any spread between the net amount paid to the pharmacy in item (iv) and the amount charged to the plan sponsor;

(vi) identity of the pharmacy for each prescription;

(vii) whether the pharmacy is, or is not, under common control or ownership with the pharmacy benefit manager;

(viii) whether the pharmacy is, or is not, a preferred pharmacy under the plan;

(ix) whether the pharmacy is, or is not, a mail order pharmacy; and

(x) whether enrollees are required by the plan to use the pharmacy;

(7) the aggregate amount of payments made by the pharmacy benefit manager to pharmacies owned or controlled by the pharmacy benefit manager;

(8) the aggregate amount of payments made by the pharmacy benefit manager to pharmacies not owned or controlled by the pharmacy benefit manager; and

(9) the aggregate amount of the fees imposed on, or collected from, network pharmacies or other assessments against network pharmacies, including point-of-sale fees and retroactive charges, and the application of those amounts collected pursuant to the contract with the plan sponsor.

Subd. 2. **Transparency report to the commissioner.** (a) Beginning June 1, 2020, and annually thereafter, each pharmacy benefit manager must submit to the commissioner of commerce a transparency report containing data from the prior calendar year. The report must contain the following information:

(1) the aggregate wholesale acquisition costs from a drug manufacturer or wholesale drug distributor for each therapeutic category of prescription drugs for all of the pharmacy benefit manager's health carrier clients and for each health carrier client, and these costs net of all rebates and other fees and payments, direct or indirect, from all sources;

(2) the aggregate amount of all rebates that the pharmacy benefit manager received from all drug manufacturers for all of the pharmacy benefit manager's health carrier clients and for each health carrier client. The aggregate amount of rebates must include any utilization discounts the pharmacy benefit manager receives from a drug manufacturer or wholesale drug distributor;

(3) the aggregate of all fees from all sources, direct or indirect, that the pharmacy benefit manager received for all of the pharmacy benefit manager's health carrier clients, and the amount of these fees for each health carrier client separately;

(4) the aggregate retained rebates and other fees, as listed in clause (3), that the pharmacy benefit manager received from all sources, direct or indirect, that were not passed through to the health carrier;

(5) the aggregate retained rebate and fees percentage;

(6) the highest, lowest, and mean aggregate retained rebate and fees percentage for all of the pharmacy benefit manager's health carrier clients and for each health carrier client; and

(7) de-identified claims level information in electronic format that allows the commissioner to sort and analyze the following information for each claim:

(i) the drug and quantity for each prescription;

(ii) whether the claim required prior authorization;

(iii) patient cost-sharing paid on each prescription;

(iv) the amount paid to the pharmacy for each prescription, net of the aggregate amount of fees or other assessments imposed on the pharmacy, including point-of-sale and retroactive charges;

(v) any spread between the net amount paid to the pharmacy in item (iv) and the amount charged to the plan sponsor;

(vi) identity of the pharmacy for each prescription;

(vii) whether the pharmacy is, or is not, under common control or ownership with the pharmacy benefit manager;

(viii) whether the pharmacy is, or is not, a preferred pharmacy under the plan;

(ix) whether the pharmacy is, or is not, a mail order pharmacy; and

(x) whether enrollees are required by the plan to use the pharmacy.

(b) Within 60 days upon receipt of the transparency report, the commissioner shall publish the report from each pharmacy benefit manager on the Department of Commerce's website, with the exception of data considered trade secret information under section 13.37.

(c) For purposes of this subdivision, the aggregate retained rebate and fee percentage must be calculated for each health carrier for rebates and fees in the previous calendar year as follows:

(1) the sum total dollar amount of rebates and fees from all drug manufacturers for all utilization of enrollees of a health carrier that was not passed through to the health carrier; and

(2) divided by the sum total dollar amount of all rebates and fees received from all sources, direct or indirect, for all enrollees of a health carrier.

Subd. 3. **Penalty.** The commissioner may impose civil penalties of not more than $1,000 per day per violation of this section.

Sec. 12. **[62W.07] PHARMACY OWNERSHIP INTEREST; SPECIALTY PHARMACY SERVICES; NONDISCRIMINATION.**

(a) A pharmacy benefit manager that has an ownership interest either directly or indirectly, or through an affiliate or subsidiary, in a pharmacy must disclose to a plan sponsor that contracts with the pharmacy benefit manager any difference between the amount paid to a pharmacy and the amount charged to the plan sponsor.

(b) A pharmacy benefit manager or a pharmacy benefit manager's affiliates or subsidiaries must not own or have an ownership interest in a patient assistance program or a mail order specialty pharmacy, unless the pharmacy benefit manager, affiliate, or subsidiary agrees to

fair competition, no self-dealing, and no interference with prospective economic advantage, and establishes a firewall between the administrative functions and the mail order pharmacy.

(c) A pharmacy benefit manager or health carrier is prohibited from penalizing, requiring, or providing financial incentives, including variations in premiums, deductibles, co-payments, or coinsurance, to an enrollee as an incentive to use a retail pharmacy, mail order pharmacy, specialty pharmacy, or other network pharmacy provider in which a pharmacy benefit manager has an ownership interest or that has an ownership interest in a pharmacy benefit manager.

(d) A pharmacy benefit manager or health carrier is prohibited from imposing limits, including quantity limits or refill frequency limits, on a patient's access to medication that differ based solely on whether the health carrier or pharmacy benefit manager has an ownership interest in a pharmacy or the pharmacy has an ownership in the pharmacy benefit manager.

(e) A pharmacy benefit manager must not require pharmacy accreditation standards or recertification requirements to participate in a network that are inconsistent with, more stringent than, or in addition to federal and state requirements for licensure as a pharmacy in this state.

(f) A pharmacy benefit manager or health carrier must not prohibit an entity authorized to participate in the federal 340B Drug Pricing Program under section 340B of the Public Health Service Act (United States Code, title 42, chapter 6A), or a pharmacy under contract with such an entity to provide pharmacy services from participating in the pharmacy benefit manager's or health carrier's provider network. A pharmacy benefit manager or health carrier must not reimburse an entity or a pharmacy under contract with such an entity participating in the federal 340B Drug Pricing Program differently than other similarly situated pharmacies. A pharmacy benefit manager that contracts with a managed care plan or county-based purchasing plan under contract with the commissioner of human services under chapter 256B or 256L must comply with this paragraph only if the entity or contracted pharmacy can identify all claims eligible for 340B drugs at the time of initial claims submission at the point-of-sale. This paragraph does not preclude a pharmacy benefit manager that contracts with a managed care plan or county-based purchasing plan under contract with the commissioner of human services under chapter 256B or 256L, from reimbursing an entity or pharmacy identified in this paragraph at a lower rate for any prescription drug purchased by the entity or pharmacy through the federal 340B Drug Pricing Program.

Sec. 13. **[62W.08] MAXIMUM ALLOWABLE COST PRICING.**

(a) With respect to each contract and contract renewal between a pharmacy benefit manager and a pharmacy, the pharmacy benefits manager must:

(1) provide to the pharmacy, at the beginning of each contract and contract renewal, the sources utilized to determine the maximum allowable cost pricing of the pharmacy benefit manager;

(2) update any maximum allowable cost price list at least every seven business days, noting any price changes from the previous list, and provide a means by which network pharmacies may promptly review current prices in an electronic, print, or telephonic format within one business day at no cost to the pharmacy;

(3) maintain a procedure to eliminate products from the list of drugs subject to maximum allowable cost pricing in a timely manner in order to remain consistent with changes in the marketplace;

(4) ensure that the maximum allowable cost prices are not set below sources utilized by the pharmacy benefits manager; and

(5) upon request of a network pharmacy, disclose the sources utilized for setting maximum allowable cost price rates on each maximum allowable cost price list included under the contract and identify each maximum allowable cost price list that applies to the network pharmacy. A pharmacy benefit manager must make the list of the maximum allowable costs available to a contracted pharmacy in a format that is readily accessible and usable to the network pharmacy.

(b) A pharmacy benefit manager must not place a prescription drug on a maximum allowable cost list unless the drug is available for purchase by pharmacies in this state from a national or regional drug wholesaler and is not obsolete.

(c) Each contract between a pharmacy benefit manager and a pharmacy must include a process to appeal, investigate, and resolve disputes regarding maximum allowable cost pricing that includes:

(1) a 15-business-day limit on the right to appeal following the initial claim;

(2) a requirement that the appeal be investigated and resolved within seven business days after the appeal is received; and

(3) a requirement that a pharmacy benefit manager provide a reason for any appeal denial and identify the national drug code of a drug that may be purchased by the pharmacy at a

price at or below the maximum allowable cost price as determined by the pharmacy benefit manager.

(d) If an appeal is upheld, the pharmacy benefit manager must make an adjustment to the maximum allowable cost price no later than one business day after the date of determination. The pharmacy benefit manager must make the price adjustment applicable to all similarly situated network pharmacy providers as defined by the plan sponsor.

Sec. 14. **[62W.09] PHARMACY AUDITS.**

Subdivision 1. **Procedure and process for conducting and reporting an audit.** (a) Unless otherwise prohibited by federal requirements or regulations, any entity conducting a pharmacy audit must follow the following procedures:

(1) a pharmacy must be given notice 14 days before an initial on-site audit is conducted;

(2) an audit that involves clinical or professional judgment must be conducted by or in consultation with a licensed pharmacist; and

(3) each pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies.

(b) Unless otherwise prohibited by federal requirements or regulations, for any entity conducting a pharmacy audit the following items apply:

(1) the period covered by the audit may not exceed 24 months from the date that the claim was submitted to or adjudicated by the entity, unless a longer period is required under state or federal law;

(2) if an entity uses random sampling as a method for selecting a set of claims for examination, the sample size must be appropriate for a statistically reliable sample. Notwithstanding section 151.69, the auditing entity shall provide the pharmacy a masked list that provides a prescription number or date range that the auditing entity is seeking to audit;

(3) an on-site audit may not take place during the first five business days of the month unless consented to by the pharmacy;

(4) auditors may not enter the pharmacy area unless escorted where patient-specific information is available and to the extent possible must be out of sight and hearing range of the pharmacy customers;

(5) any recoupment will not be deducted against future remittances until after the appeals process and both parties have received the results of the final audit;

(6) a pharmacy benefit manager may not require information to be written on a prescription unless the information is required to be written on the prescription by state or federal law. Recoupment may be assessed for items not written on the prescription if:

(i) additional information is required in the provider manual; or

(ii) the information is required by the Food and Drug Administration (FDA); or

(iii) the information is required by the drug manufacturer's product safety program; and

(iv) the information in item (i), (ii), or (iii) is not readily available for the auditor at the time of the audit; and

(7) the auditing company or agent may not receive payment based on a percentage of the amount recovered. This section does not prevent the entity conducting the audit from charging or assessing the responsible party, directly or indirectly, based on amounts recouped if both of the following conditions are met:

(i) the plan sponsor and the entity conducting the audit have a contract that explicitly states the percentage charge or assessment to the plan sponsor; and

(ii) a commission to an agent or employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped.

(c) An amendment to pharmacy audit terms in a contract between a pharmacy benefit manager and a pharmacy must be disclosed to the pharmacy at least 60 days prior to the effective date of the proposed change.

Subd. 2. **Requirement for recoupment or chargeback.** For recoupment or chargeback, the following criteria apply:

(1) audit parameters must consider consumer-oriented parameters based on manufacturer listings;

(2) a pharmacy's usual and customary price for compounded medications is considered the reimbursable cost unless the pricing methodology is outlined in the pharmacy provider contract;

(3) a finding of overpayment or underpayment must be based on the actual overpayment or underpayment and not a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs;

(4) the entity conducting the audit shall not use extrapolation in calculating the recoupment or penalties for audits unless required by state or federal law or regulations;

(5) calculations of overpayments must not include dispensing fees unless a prescription was not actually dispensed, the prescriber denied authorization, the prescription dispensed was a medication error by the pharmacy, or the identified overpayment is solely based on an extra dispensing fee;

(6) an entity may not consider any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error regarding a required document or record as fraud, however such errors may be subject to recoupment;

(7) in the case of errors that have no actual financial harm to the patient or plan, the pharmacy benefit manager must not assess any chargebacks. Errors that are a result of the pharmacy failing to comply with a formal corrective action plan may be subject to recovery; and

(8) interest may not accrue during the audit period for either party, beginning with the notice of the audit and ending with the final audit report.

Subd. 3. **Documentation.** (a) To validate the pharmacy record and delivery, the pharmacy may use authentic and verifiable statements or records including medication administration records of a nursing home, assisted living facility, hospital, physician, or other authorized practitioner or additional audit documentation parameters located in the provider manual.

(b) Any legal prescription that meets the requirements in this chapter may be used to validate claims in connection with prescriptions, refills, or changes in prescriptions, including medication administration records, faxes, e-prescriptions, or documented telephone calls from the prescriber or the prescriber's agents.

Subd. 4. **Appeals process.** The entity conducting the audit must establish a written appeals process which must include appeals of preliminary reports and final reports.

Subd. 5. **Audit information and reports.** (a) A preliminary audit report must be delivered to the pharmacy within 60 days after the conclusion of the audit.

(b) A pharmacy must be allowed at least 45 days following receipt of the preliminary audit to provide documentation to address any discrepancy found in the audit.

(c) A final audit report must be delivered to the pharmacy within 120 days after receipt of the preliminary audit report or final appeal, whichever is later.

(d) An entity shall remit any money due to a pharmacy or pharmacist as a result of an underpayment of a claim within 45 days after the appeals process has been exhausted and the final audit report has been issued.

Subd. 6. **Disclosure to plan sponsor.** Where contractually required, an auditing entity must provide a copy to the plan sponsor of its claims that were included in the audit, and any recouped money shall be returned to the plan sponsor.

Subd. 7. **Applicability of other laws and regulations.** This section does not apply to any investigative audit that involves suspected fraud, willful misrepresentation, abuse, or any audit completed by Minnesota health care programs.

Subd. 8. **Definitions.** For purposes of this section, "entity" means a pharmacy benefits manager or any person or organization that represents these companies, groups, or organizations.

Sec. 15. **[62W.10] SYNCHRONIZATION.**

(a) For purposes of this section, "synchronization" means the coordination of prescription drug refills for a patient taking two or more medications for one or more chronic conditions, to allow the patient's medications to be refilled on the same schedule for a given period of time.

(b) A contract between a pharmacy benefit manager and a pharmacy must allow for synchronization of prescription drug refills for a patient on at least one occasion per year, if the following criteria are met:

(1) the prescription drugs are covered under the patient's health plan or have been approved by a formulary exceptions process;

(2) the prescription drugs are maintenance medications as defined by the health plan and have one or more refills available at the time of synchronization;

(3) the prescription drugs are not Schedule II, III, or IV controlled substances;

(4) the patient meets all utilization management criteria relevant to the prescription drug at the time of synchronization;

(5) the prescription drugs are of a formulation that can be safely split into short-fill periods to achieve synchronization; and

(6) the prescription drugs do not have special handling or sourcing needs that require a single, designated pharmacy to fill or refill the prescription.

(c) When necessary to permit synchronization, the pharmacy benefit manager must apply a prorated, daily patient cost-sharing rate to any prescription drug dispensed by a pharmacy under this section. The dispensing fee must not be prorated, and all dispensing fees shall be based on the number of prescriptions filled or refilled.

(d) Synchronization may be requested by the patient or by the patient's parent or legal guardian. For purposes of this paragraph, "legal guardian" includes but is not limited to a guardian of an incapacitated person appointed pursuant to chapter 524.

Sec. 16. **[62W.11] GAG CLAUSE PROHIBITION.**

(a) No contract between a pharmacy benefit manager or health carrier and a pharmacy or pharmacist shall prohibit, restrict, or penalize a pharmacy or pharmacist from disclosing to an enrollee any health care information that the pharmacy or pharmacist deems appropriate regarding the nature of treatment; the risks or alternatives; the availability of alternative therapies, consultations, or tests; the decision of utilization reviewers or similar persons to authorize or deny services; the process that is used to authorize or deny health care services or benefits; or information on financial incentives and structures used by the health carrier or pharmacy benefit manager.

(b) A pharmacy or pharmacist must provide to an enrollee information regarding the enrollee's total cost for each prescription drug dispensed where part or all of the cost of the prescription is being paid or reimbursed by the employer-sponsored plan or by a health carrier or pharmacy benefit manager, in accordance with section 151.214, subdivision 1.

(c) A pharmacy benefit manager or health carrier must not prohibit a pharmacist or pharmacy from discussing information regarding the total cost for pharmacy services for a prescription drug, including the patient's co-payment amount, the pharmacy's own usual and customary price of the prescription, and the net amount the pharmacy will receive from all sources for dispensing the prescription drug, once the claim has been completed by the pharmacy benefit manager or the patient's health carrier.

(d) A pharmacy benefit manager or health carrier must not prohibit a pharmacist or pharmacy from discussing the availability of any therapeutically equivalent alternative prescription drugs or alternative methods for purchasing the prescription drug, including but not limited to paying out-of-pocket the pharmacy's usual and customary price when that amount is less expensive to the enrollee than the amount the enrollee is required to pay for the prescription drug under the enrollee's health plan.

Sec. 17. **[62W.12] POINT OF SALE.**

No pharmacy benefit manager or health carrier shall require an enrollee to make a payment at the point of sale for a covered prescription drug in an amount greater than the lesser of:

(1) the applicable co-payment for the prescription drug;

(2) the allowable claim amount for the prescription drug;

(3) the amount an enrollee would pay for the prescription drug if the enrollee purchased the prescription drug without using a health plan or any other source of prescription drug benefits or discounts; or

(4) the amount the pharmacy will be reimbursed for the prescription drug from the pharmacy benefit manager or health carrier.

Sec. 18. **[62W.13] RETROACTIVE ADJUSTMENTS.**

No pharmacy benefit manager shall retroactively adjust a claim for reimbursement submitted by a pharmacy for a prescription drug, unless the adjustment is a result of a:

(1) pharmacy audit conducted in accordance with section 62W.09; or

(2) technical billing error.

Sec. 19. Minnesota Statutes 2018, section 147.37, is amended to read:

**147.37 INFORMATION PROVISION; PHARMACEUTICAL ASSISTANCE PROGRAMS.**

At least annually, the board shall encourage licensees who are authorized to prescribe drugs to make available to patients information on ~~free and discounted prescription drug programs offered by pharmaceutical manufacturers when the information is provided to the licensees at no cost~~ sources of lower cost prescription drugs and shall provide these licensees with the address for the website established by the Board of Pharmacy pursuant to section 151.06, subdivision 6.

Sec. 20. **[148.192] INFORMATION PROVISION; PHARMACEUTICAL ASSISTANCE PROGRAMS.**

At least annually, the board shall encourage licensees who are authorized to prescribe drugs to make available to patients information on sources of lower cost prescription drugs and shall provide these licensees with the address for the website established by the Board of Pharmacy pursuant to section 151.06, subdivision 6.

Sec. 21. Minnesota Statutes 2018, section 151.01, subdivision 23, is amended to read:

Subd. 23. **Practitioner.** "Practitioner" means a licensed doctor of medicine, licensed doctor of osteopathic medicine duly licensed to practice medicine, licensed doctor of dentistry, licensed doctor of optometry, licensed podiatrist, licensed veterinarian, or licensed advanced practice registered nurse. For purposes of sections 151.15, subdivision 4; 151.211, subdivision 3; 151.252, subdivision 3; 151.37, subdivision 2, paragraphs (b), (e), and (f); and 151.461, "practitioner" also means a physician assistant authorized to prescribe, dispense, and administer under chapter 147A. For purposes of sections 151.15, subdivision 4; 151.211, subdivision 3; 151.252, subdivision 3; 151.37, subdivision 2, paragraph (b); and 151.461, "practitioner" also means a dental therapist authorized to dispense and administer under chapter 150A.

Sec. 22. Minnesota Statutes 2018, section 151.06, is amended by adding a subdivision to read:

Subd. 6. **Information provision; sources of lower cost prescription drugs.** (a) The board shall publish a page on its website that provides regularly updated information concerning:

(1) pharmaceutical manufacturer patient assistance programs;

(2) the prescription drug assistance program established by the Minnesota Board of Aging under section 256.975, subdivision 9;

(3) the emergency insulin assistance program established under section 256.937;

(4) the websites through which individuals can access information concerning eligibility for and enrollment in Medicare, medical assistance, MinnesotaCare, and other government-funded programs that help pay for the cost of health care;

(5) the program established under section 340b of the federal Public Health Services Act, United States Code, title 42, section 256b; and

(6) any other resource that the board deems useful to individuals who are attempting to purchase prescription drugs at lower costs.

(b) The board shall prepare educational documents and materials, including brochures and posters, based on the information it provides on its website under paragraph (a). The documents and materials shall be in a form that can be downloaded from the board's website and used for patient education by pharmacists and by practitioners who are licensed to

prescribe. The board is not required to provide printed copies of these documents and materials.

(c) At least annually, the board shall encourage licensed pharmacists and pharmacies to make available to patients information on sources of lower cost prescription drugs and shall provide these licensees with the address for the website established under paragraph (a).

Sec. 23. Minnesota Statutes 2018, section 151.071, subdivision 1, is amended to read:

Subdivision 1. **Forms of disciplinary action.** When the board finds that a licensee, registrant, or applicant has engaged in conduct prohibited under subdivision 2, it may do one or more of the following:

(1) deny the issuance of a license or registration;

(2) refuse to renew a license or registration;

(3) revoke the license or registration;

(4) suspend the license or registration;

(5) impose limitations, conditions, or both on the license or registration, including but not limited to: the limitation of practice to designated settings; the limitation of the scope of practice within designated settings; the imposition of retraining or rehabilitation requirements; the requirement of practice under supervision; the requirement of participation in a diversion program such as that established pursuant to section 214.31 or the conditioning of continued practice on demonstration of knowledge or skills by appropriate examination or other review of skill and competence;

(6) impose a civil penalty not exceeding $10,000 for each separate violation, except that a civil penalty not exceeding $25,000 may be imposed for each separate violation of section 151.462, the amount of the civil penalty to be fixed so as to deprive a licensee or registrant of any economic advantage gained by reason of the violation, to discourage similar violations by the licensee or registrant or any other licensee or registrant, or to reimburse the board for the cost of the investigation and proceeding, including but not limited to, fees paid for services provided by the Office of Administrative Hearings, legal and investigative services provided by the Office of the Attorney General, court reporters, witnesses, reproduction of records, board members' per diem compensation, board staff time, and travel costs and expenses incurred by board staff and board members; and

(7) reprimand the licensee or registrant.

Sec. 24. Minnesota Statutes 2018, section 151.071, subdivision 2, is amended to read:

Subd. 2. **Grounds for disciplinary action.** The following conduct is prohibited and is grounds for disciplinary action:

(1) failure to demonstrate the qualifications or satisfy the requirements for a license or registration contained in this chapter or the rules of the board. The burden of proof is on the applicant to demonstrate such qualifications or satisfaction of such requirements;

(2) obtaining a license by fraud or by misleading the board in any way during the application process or obtaining a license by cheating, or attempting to subvert the licensing examination process. Conduct that subverts or attempts to subvert the licensing examination process includes, but is not limited to: (i) conduct that violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination; (ii) conduct that violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials; or (iii) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf;

(3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration, conviction of a felony reasonably related to the practice of pharmacy. Conviction as used in this subdivision includes a conviction of an offense that if committed in this state would be deemed a felony without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered thereon. The board may delay the issuance of a new license or registration if the applicant has been charged with a felony until the matter has been adjudicated;

(4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner or applicant is convicted of a felony reasonably related to the operation of the facility. The board may delay the issuance of a new license or registration if the owner or applicant has been charged with a felony until the matter has been adjudicated;

(5) for a controlled substance researcher, conviction of a felony reasonably related to controlled substances or to the practice of the researcher's profession. The board may delay the issuance of a registration if the applicant has been charged with a felony until the matter has been adjudicated;

(6) disciplinary action taken by another state or by one of this state's health licensing agencies:

(i) revocation, suspension, restriction, limitation, or other disciplinary action against a license or registration in another state or jurisdiction, failure to report to the board that charges or allegations regarding the person's license or registration have been brought in another state or jurisdiction, or having been refused a license or registration by any other state or jurisdiction. The board may delay the issuance of a new license or registration if an investigation or disciplinary action is pending in another state or jurisdiction until the investigation or action has been dismissed or otherwise resolved; and

(ii) revocation, suspension, restriction, limitation, or other disciplinary action against a license or registration issued by another of this state's health licensing agencies, failure to report to the board that charges regarding the person's license or registration have been brought by another of this state's health licensing agencies, or having been refused a license or registration by another of this state's health licensing agencies. The board may delay the issuance of a new license or registration if a disciplinary action is pending before another of this state's health licensing agencies until the action has been dismissed or otherwise resolved;

(7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of any order of the board, of any of the provisions of this chapter or any rules of the board or violation of any federal, state, or local law or rule reasonably pertaining to the practice of pharmacy;

(8) for a facility, other than a pharmacy, licensed by the board, violations of any order of the board, of any of the provisions of this chapter or the rules of the board or violation of any federal, state, or local law relating to the operation of the facility;

(9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient; or pharmacy practice that is professionally incompetent, in that it may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established;

(10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy technician or pharmacist intern if that person is performing duties allowed by this chapter or the rules of the board;

(11) for an individual licensed or registered by the board, adjudication as mentally ill or developmentally disabled, or as a chemically dependent person, a person dangerous to the public, a sexually dangerous person, or a person who has a sexual psychopathic personality, by a court of competent jurisdiction, within or without this state. Such adjudication shall automatically suspend a license for the duration thereof unless the board orders otherwise;

(12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist intern or performing duties specifically reserved for pharmacists under this chapter or the rules of the board;

(13) for a pharmacy, operation of the pharmacy without a pharmacist present and on duty except as allowed by a variance approved by the board;

(14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety to patients by reason of illness, drunkenness, use of drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills. In the case of registered pharmacy technicians, pharmacist interns, or controlled substance researchers, the inability to carry out duties allowed under this chapter or the rules of the board with reasonable skill and safety to patients by reason of illness, drunkenness, use of drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills;

(15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas distributor, or controlled substance researcher, revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law;

(16) for a pharmacist or pharmacy, improper management of patient records, including failure to maintain adequate patient records, to comply with a patient's request made pursuant to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

(17) fee splitting, including without limitation:

(i) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate, kickback, or other form of remuneration, directly or indirectly, for the referral of patients; and

(ii) referring a patient to any health care provider as defined in sections 144.291 to 144.298 in which the licensee or registrant has a financial or economic interest as defined in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the licensee's or registrant's financial or economic interest in accordance with section 144.6521;

(18) engaging in abusive or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws or rules;

(19) engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient;

(20) failure to make reports as required by section 151.072 or to cooperate with an investigation of the board as required by section 151.074;

(21) knowingly providing false or misleading information that is directly related to the care of a patient unless done for an accepted therapeutic purpose such as the dispensing and administration of a placebo;

(22) aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

(i) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;

(ii) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;

(iii) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or

(iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board shall investigate any complaint of a violation of section 609.215, subdivision 1 or 2;

(23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For a pharmacist intern, pharmacy technician, or controlled substance researcher, performing duties permitted to such individuals by this chapter or the rules of the board under a lapsed or nonrenewed registration. For a facility required to be licensed under this chapter, operation of the facility under a lapsed or nonrenewed license or registration; ~~and~~

(24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge from the health professionals services program for reasons other than the satisfactory completion of the program ~~.~~; and

(25) for a manufacturer or wholesale drug distributor, a violation of section 151.462.

Sec. 25. Minnesota Statutes 2018, section 151.21, subdivision 7, is amended to read:

Subd. 7. **Drug formulary.** ~~This section~~ Subdivision 3 does not apply when a pharmacist is dispensing a prescribed drug to persons covered under a managed health care plan that maintains a mandatory or closed drug formulary.

Sec. 26. Minnesota Statutes 2018, section 151.21, is amended by adding a subdivision to read:

Subd. 7a. **Coverage by substitution.** (a) When a pharmacist receives a prescription order by paper or hard copy, by electronic transmission, or by oral instruction from the prescriber, in which the prescriber has not expressly indicated that the prescription is to be dispensed as communicated and the drug prescribed is not covered under the purchaser's health plan or prescription drug plan, the pharmacist may dispense a therapeutically equivalent and interchangeable prescribed drug or biological product that is covered under the purchaser's plan, if the pharmacist has a written protocol with the prescriber that outlines the class of drugs of the same generation and designed for the same indication that can be substituted and the required communication between the pharmacist and the prescriber.

(b) The pharmacist must inform the purchaser if the pharmacist is dispensing a drug or biological product other than the specific drug or biological product prescribed and the reason for the substitution.

(c) The pharmacist must communicate to the prescriber the name and manufacturer of the substituted drug that was dispensed and the reason for the substitution, in accordance with the written protocol.

Sec. 27. Minnesota Statutes 2018, section 151.211, subdivision 2, is amended to read:

Subd. 2. **Refill requirements.** Except as provided in subdivision 3, a prescription drug order may be refilled only with the written, electronic, or verbal consent of the prescriber and in accordance with the requirements of this chapter, the rules of the board, and where applicable, section 152.11. The date of such refill must be recorded and initialed upon the original prescription drug order, or within the electronically maintained record of the original

prescription drug order, by the pharmacist, pharmacist intern, or practitioner who refills the prescription.

Sec. 28. Minnesota Statutes 2018, section 151.211, is amended by adding a subdivision to read:

Subd. 3. **Emergency prescription refills.** (a) A pharmacist may, using sound professional judgment and in accordance with accepted standards of practice, dispense a legend drug without a current prescription drug order from a licensed practitioner if all of the following conditions are met:

(1) the patient has been compliant with taking the medication and has consistently had the drug filled or refilled as demonstrated by records maintained by the pharmacy;

(2) the pharmacy from which the legend drug is dispensed has record of a prescription drug order for the drug in the name of the patient who is requesting it, but the prescription drug order does not provide for a refill, or the time during which the refills were valid has elapsed;

(3) the pharmacist has tried but is unable to contact the practitioner who issued the prescription drug order, or another practitioner responsible for the patient's care, to obtain authorization to refill the prescription;

(4) the drug is essential to sustain the life of the patient or to continue therapy for a chronic condition;

(5) failure to dispense the drug to the patient would result in harm to the health of the patient; and

(6) the drug is not a controlled substance listed in section 152.02, subdivisions 3 to 6, except for a controlled substance that has been specifically prescribed to treat a seizure disorder, in which case the pharmacist may dispense up to a 72-hour supply.

(b) If the conditions in paragraph (a) are met, the amount of the drug dispensed by the pharmacist to the patient must not exceed a 30-day supply, or the quantity originally prescribed, whichever is less, except as provided for controlled substances in paragraph (a), clause (6). If the standard unit of dispensing for the drug exceeds a 30-day supply, the amount of the drug dispensed or sold must not exceed the standard unit of dispensing.

(c) A pharmacist shall not dispense or sell the same drug to the same patient, as provided in this section, more than one time in any 12-month period.

(d) A pharmacist must notify the practitioner who issued the prescription drug order not later than 72 hours after the drug is sold or dispensed. The pharmacist must request and receive authorization before any additional refills may be dispensed. If the practitioner declines to provide authorization for additional refills, the pharmacist must inform the patient of that fact.

(e) The record of a drug sold or dispensed under this section shall be maintained in the same manner required for prescription drug orders under this section.

Sec. 29. Minnesota Statutes 2018, section 151.252, subdivision 1, is amended to read:

Subdivision 1. **Requirements.** (a) No person shall act as a drug manufacturer without first obtaining a license from the board and paying any applicable fee specified in section 151.065.

(b) In addition to the license required under paragraph (a), a manufacturer of insulin must pay the applicable insulin registration fee in section 151.254, by June 1 of each year, beginning June 1, 2020. In the event of a change of ownership of the manufacturer, the new owner must pay the registration fee in section 151.254 that the original owner would have been assessed had it retained ownership. The board may assess a late fee of ten percent per month for any portion of a month that the registration fee is paid after the due date. The registration fee collected under this paragraph, including any late fees, shall be deposited in the insulin assistance account established under section 256.938.

~~(b)~~ (c) Application for a drug manufacturer license under this section shall be made in a manner specified by the board.

~~(c)~~ (d) No license shall be issued or renewed for a drug manufacturer unless the applicant agrees to operate in a manner prescribed by federal and state law and according to Minnesota Rules.

~~(d)~~ (e) No license shall be issued or renewed for a drug manufacturer that is required to be registered pursuant to United States Code, title 21, section 360, unless the applicant supplies the board with proof of registration. The board may establish by rule the standards for licensure of drug manufacturers that are not required to be registered under United States Code, title 21, section 360.

~~(e)~~ (f) No license shall be issued or renewed for a drug manufacturer that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of licensure or registration. The board may establish, by rule,

standards for the licensure of a drug manufacturer that is not required to be licensed or registered by the state in which it is physically located.

~~(f)~~ (g) The board shall require a separate license for each facility located within the state at which drug manufacturing occurs and for each facility located outside of the state at which drugs that are shipped into the state are manufactured.

~~(g)~~ (h) The board shall not issue an initial or renewed license for a drug manufacturing facility unless the facility passes an inspection conducted by an authorized representative of the board. In the case of a drug manufacturing facility located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located or by the United States Food and Drug Administration, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

Sec. 30. **[151.254] INSULIN REGISTRATION FEE.**

Subdivision 1. **Definition.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "Manufacturer" means a manufacturer licensed under section 151.252 engaged in the manufacturing of insulin.

(c) "Wholesaler" means a wholesale drug distributor licensed under section 151.47 and engaged in the wholesale drug distribution of insulin.

Subd. 2. **Reporting requirements.** (a) Effective March 1 of each year, beginning March 1, 2020, each manufacturer and each wholesaler must report to the Board of Pharmacy every sale, delivery, or other distribution within or into the state of insulin that was made to any practitioner, pharmacy, hospital, or other person who is permitted by section 151.37 to possess insulin for administration or was dispensed to human patients during the previous calendar year. Reporting must be in a manner specified by the board. If the manufacturer or wholesaler fails to provide information required under this paragraph on a timely basis, the board may assess an administrative penalty of $100 per day. This penalty shall not be considered a form of disciplinary action. Any penalty assessed under this section shall be deposited in the insulin assistance account established under section 256.938.

(b) By March 1 of each year, beginning March 1, 2020, each owner of a pharmacy with at least one location within this state must report to the board any intracompany delivery or distribution of insulin into this state, to the extent that those deliveries and distributions are not reported to the board by a licensed wholesaler owned by, under contract to, or otherwise operating on behalf of the owner of the pharmacy. Reporting must be in the manner and format specified by the board for deliveries and distributions that occurred during the previous calendar year. The report must include the name of the manufacturer or wholesaler from which the owner of the pharmacy ultimately purchased the insulin and the amount and date the purchase occurred.

Subd. 3. **Determination of manufacturer's registration fee.** (a) The board shall annually assess manufacturers a registration fee that in aggregate equals the total cost of the insulin assistance program established under section 256.937 for the previous fiscal year, including any administration costs incurred by the commissioner of human services or the board in collecting the fee. The board shall determine each manufacturer's annual insulin registration fee that is prorated and based on the manufacturer's percentage of the total number of units reported to the board under subdivision 2. For the first assessment, the commissioner shall estimate the cost of the program for the first fiscal year and notify the board of the estimated cost by March 1, 2020. The board shall determine each manufacturer's initial registration fee based on the estimated cost.

(b) By April 1 of each year, beginning April 1, 2020, the board shall notify each manufacturer of the annual amount of the manufacturer's insulin registration fee to be paid in accordance with section 151.252, subdivision 1, paragraph (b).

(c) A manufacturer may dispute the fee assessed under this section as determined by the board no later than 30 days after the date of notification. However, the manufacturer must still remit the registration fee required by section 151.252, subdivision 1, paragraph (b). The dispute must be filed with the board in the manner and using the forms specified by the board. A manufacturer must submit, with the required forms, data satisfactory to the board that demonstrates that the fee was incorrect or otherwise unwarranted. The board must make a decision concerning a dispute no later than 60 days after receiving the required dispute forms. If the board determines that the manufacturer has satisfactorily demonstrated that the original fee was incorrect, the board must: (1) adjust the manufacturer's fee; (2) adjust the manufacturer's fee due the next year by the amount in excess of the correct fee that should have been paid; or (3) refund the amount paid in error.

Sec. 31. **[151.462] PROHIBITION AGAINST CHARGING UNCONSCIONABLE PRICES FOR PRESCRIPTION DRUGS.**

Subdivision 1. **Purpose.** The purpose of this section is to promote public health in Minnesota by preventing unconscionable price gouging with respect to the price of essential prescription drugs sold in Minnesota. Essential prescription drugs are a necessity. These drugs, which are made available in this state by drug manufacturers and wholesale distributors, provide critically important benefits to the health and well-being of Minnesota citizens. Abuses in the pricing of various essential prescription drugs are well-documented, jeopardize the health and welfare of the public, and have caused the death of patients who could not afford to pay an unconscionable price for these drugs. For example, these price gouging practices have created a public health catastrophe in Minnesota regarding the sale of insulin, an essential prescription drug for the treatment of more than 320,000 people residing in Minnesota who are diabetic. This section is intended to address such abuses, but allow drug manufacturers and wholesale drug distributors a fair rate of return with respect to their sale of essential prescription drugs in the state of Minnesota.

Subd. 2. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Essential prescription drug" means a patented (including an exclusivity-protected drug), off-patent, or generic drug prescribed in Minnesota by a practitioner:

(1) that either:

(i) is covered under the medical assistance program or by any Medicare Part D plan offered in the state of Minnesota; or

(ii) has been designated by the commissioner of human services under subdivision 4 as an essential medicine due to its efficacy in treating a life-threatening health condition or a chronic health condition that substantially impairs an individual's ability to engage in activities of daily living; and

(2) for which:

(i) a 30-day supply of the maximum recommended dosage of the drug for any indication, according to the label for the drug approved under the Federal Food, Drug, and Cosmetic Act, would cost more than $80 at the drug's wholesale acquisition cost;

(ii) a full course of treatment with the drug, according to the label for the drug approved under the Federal Food, Drug, and Cosmetic Act, would cost more than $80 at the drug's wholesale acquisition cost; or

(iii) if the drug is made available to consumers only in quantities that do not correspond to a 30-day supply, a full course of treatment, or a single dose, it would cost more than $80 at the drug's wholesale acquisition cost to obtain a 30-day supply or a full course of treatment.

Essential prescription drug also includes a patented or off-patent drug-device combination product, whose wholesale acquisition cost is more than $80, and which is used at least in part for delivery of a drug described in this paragraph.

(c) "Health plan company" has the meaning provided in section 62Q.01, subdivision 4.

(d) "Unconscionable price" means a price that:

(1) is not reasonably justified by the actual cost of inventing, producing, selling, and distributing the essential prescription drug, and any actual cost of an appropriate expansion of access to the drug to promote public health; and

(2) applies to an essential prescription drug sold to:

(i) consumers in Minnesota;

(ii) the commissioner of human services for use in a Minnesota public health care program; or

(iii) a health plan company providing medical care to Minnesota consumers; and the consumer, commissioner, or health plan company has no meaningful choice about whether to purchase the drug, because there is no other comparable drug sold in Minnesota at a price that is reasonably justified by the actual cost of inventing, producing, selling, and distributing the comparable drug, and any actual cost of an appropriate expansion of access to the drug to promote public health.

(e) "Wholesale acquisition cost" has the meaning given in United States Code, title 42, section 1395w-3a.

Subd. 3. **Prohibition.** No drug manufacturer or wholesale drug distributor shall charge or cause to be charged in Minnesota an unconscionable price for an essential prescription drug sold in Minnesota. It is not a violation of this section for a wholesale drug distributor to charge a price for an essential prescription drug to be sold in Minnesota that is directly and substantially attributable to the cost of the drug charged by the manufacturer.

Subd. 4. **Commissioner of human services; list of essential prescription drugs.** The commissioner of human services, in consultation with the Formulary Committee established under section 256B.0625, subdivision 13c, may designate essential medicines in accordance with subdivision 2, paragraph (b), clause (1), item (ii), and shall maintain a list of all essential

prescription drugs on the agency website. The commissioner is exempt from the rulemaking requirements of chapter 14 in making the essential medicine designation and compiling the list of all essential prescription drugs under this subdivision.

Subd. 5. **Notification of attorney general.** The Minnesota Board of Pharmacy, the commissioner of human services, and health plan companies providing health coverage to Minnesota consumers, shall notify the attorney general of any increase of 15 percent or more during a one-year period in the price of any essential prescription drug sold in Minnesota.

Subd. 6. **Attorney general's office to confer with drug manufacturer or distributor.** In order for the attorney general to bring an action for an alleged violation of subdivision 3 against a drug manufacturer or wholesale distributor, the attorney general must have provided the manufacturer or wholesale distributor an opportunity to meet with the attorney general to present any justification for the price of the essential prescription drug. This meeting shall be in addition to any response or responses that the drug manufacturer or wholesale distributor may make to prelitigation investigation or discovery conducted by the attorney general pursuant to section 8.31.

Subd. 7. **Private right of action.** Any action brought pursuant to section 8.31, subdivision 3a, by a person injured by a violation of this section is for the benefit of the public.

Subd. 8. **Severability.** In accordance with section 645.20, it is the intent of the legislature that the provisions, or any part of a provision, of this section or its effective date are severable in the event any provision, or any part of a provision, of this section or its effective date is found by a court to be unconstitutional.

**EFFECTIVE DATE.** This section is effective the day following final enactment and, notwithstanding any statutory or common law to the contrary, applies retroactively to any prices charged by a drug manufacturer or drug wholesaler for essential prescription drugs sold or distributed in Minnesota on or after July 1, 2014.

Sec. 32. **[151.555] PRESCRIPTION DRUG REPOSITORY PROGRAM.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Central repository" means a wholesale distributor that meets the requirements under subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this section.

(c) "Distribute" means to deliver, other than by administering or dispensing.

(d) "Donor" means:

(1) a health care facility as defined in this subdivision;

(2) a skilled nursing facility licensed under chapter 144A;

(3) an assisted living facility registered under chapter 144D where there is centralized storage of drugs and 24-hour on-site licensed nursing coverage provided seven days a week;

(4) a pharmacy licensed under section 151.19, and located either in the state or outside the state;

(5) a drug wholesaler licensed under section 151.47;

(6) a drug manufacturer licensed under section 151.252; or

(7) an individual at least 18 years of age, provided that the drug or medical supply that is donated was obtained legally and meets the requirements of this section for donation.

(e) "Drug" means any prescription drug that has been approved for medical use in the United States, is listed in the United States Pharmacopoeia or National Formulary, and meets the criteria established under this section for donation. This definition includes cancer drugs and antirejection drugs, but does not include controlled substances, as defined in section 152.01, subdivision 4, or a prescription drug that can only be dispensed to a patient registered with the drug's manufacturer in accordance with federal Food and Drug Administration requirements.

(f) "Health care facility" means:

(1) a physician's office or health care clinic where licensed practitioners provide health care to patients;

(2) a hospital licensed under section 144.50;

(3) a pharmacy licensed under section 151.19 and located in Minnesota; or

(4) a nonprofit community clinic, including a federally qualified health center; a rural health clinic; public health clinic; or other community clinic that provides health care utilizing a sliding fee scale to patients who are low-income, uninsured, or underinsured.

(g) "Local repository" means a health care facility that elects to accept donated drugs and medical supplies and meets the requirements of subdivision 4.

(h) "Medical supplies" or "supplies" means any prescription and nonprescription medical supply needed to administer a prescription drug.

(i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules, part 6800.3750.

(j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that it does not include a veterinarian.

Subd. 2. **Establishment.** By January 1, 2020, the Board of Pharmacy shall establish a drug repository program, through which donors may donate a drug or medical supply for use by an individual who meets the eligibility criteria specified under subdivision 5. The board shall contract with a central repository that meets the requirements of subdivision 3 to implement and administer the prescription drug repository program.

Subd. 3. **Central repository requirements.** (a) The board shall publish a request for proposal for participants who meet the requirements of this subdivision and are interested in acting as the central repository for the drug repository program. The board shall follow all applicable state procurement procedures in the selection process.

(b) To be eligible to act as the central repository, the participant must be a wholesale drug distributor located in Minnesota, licensed pursuant to section 151.47, and in compliance with all applicable federal and state statutes, rules, and regulations.

(c) The central repository shall be subject to inspection by the board pursuant to section 151.06, subdivision 1.

(d) The central repository shall comply with all applicable federal and state laws, rules, and regulations pertaining to the drug repository program, drug storage, and dispensing. The facility must maintain in good standing any state license or registration that applies to the facility.

Subd. 4. **Local repository requirements.** (a) To be eligible for participation in the drug repository program, a health care facility must agree to comply with all applicable federal and state laws, rules, and regulations pertaining to the drug repository program, drug storage, and dispensing. The facility must also agree to maintain in good standing any required state license or registration that may apply to the facility.

(b) A local repository may elect to participate in the program by submitting the following information to the central repository on a form developed by the board and made available on the board's website:

(1) the name, street address, and telephone number of the health care facility and any state-issued license or registration number issued to the facility, including the issuing state agency;

(2) the name and telephone number of a responsible pharmacist or practitioner who is employed by or under contract with the health care facility; and

(3) a statement signed and dated by the responsible pharmacist or practitioner indicating that the health care facility meets the eligibility requirements under this section and agrees to comply with this section.

(c) Participation in the drug repository program is voluntary. A local repository may withdraw from participation in the drug repository program at any time by providing written notice to the central repository on a form developed by the board and made available on the board's website. The central repository shall provide the board with a copy of the withdrawal notice within ten business days from the date of receipt of the withdrawal notice.

Subd. 5. **Individual eligibility and application requirements.** (a) To be eligible for the drug repository program, an individual must submit to a local repository an intake application form that is signed by the individual and attests that the individual:

(1) is a resident of Minnesota;

(2) is uninsured and is not enrolled in the medical assistance program under chapter 256B or the MinnesotaCare program under chapter 256L, has no prescription drug coverage, or is underinsured;

(3) acknowledges that the drugs or medical supplies to be received through the program may have been donated; and

(4) consents to a waiver of the child-resistant packaging requirements of the federal Poison Prevention Packaging Act.

(b) Upon determining that an individual is eligible for the program, the local repository shall furnish the individual with an identification card. The card shall be valid for one year from the date of issuance and may be used at any local repository. A new identification card may be issued upon expiration once the individual submits a new application form.

(c) The local repository shall send a copy of the intake application form to the central repository by regular mail, facsimile, or secured e-mail within ten days from the date the application is approved by the local repository.

(d) The board shall develop and make available on the board's website an application form and the format for the identification card.

Subd. 6. **Standards and procedures for accepting donations of drugs and supplies.** (a) A donor may donate prescription drugs or medical supplies to the central repository or a local repository if the drug or supply meets the requirements of this section as determined by a pharmacist or practitioner who is employed by or under contract with the central repository or a local repository.

(b) A prescription drug is eligible for donation under the drug repository program if the following requirements are met:

(1) the donation is accompanied by a drug repository donor form described under paragraph (d) that is signed by an individual who is authorized by the donor to attest to the donor's knowledge in accordance with paragraph (d);

(2) the drug's expiration date is at least six months after the date the drug was donated. If a donated drug bears an expiration date that is less than six months from the donation date, the drug may be accepted and distributed if the drug is in high demand and can be dispensed for use by a patient before the drug's expiration date;

(3) the drug is in its original, sealed, unopened, tamper-evident packaging that includes the expiration date. Single-unit-dose drugs may be accepted if the single-unit-dose packaging is unopened;

(4) the drug or the packaging does not have any physical signs of tampering, misbranding, deterioration, compromised integrity, or adulteration;

(5) the drug does not require storage temperatures other than normal room temperature as specified by the manufacturer or United States Pharmacopoeia, unless the drug is being donated directly by its manufacturer, a wholesale drug distributor, or a pharmacy located in Minnesota; and

(6) the prescription drug is not a controlled substance.

(c) A medical supply is eligible for donation under the drug repository program if the following requirements are met:

(1) the supply has no physical signs of tampering, misbranding, or alteration and there is no reason to believe it has been adulterated, tampered with, or misbranded;

(2) the supply is in its original, unopened, sealed packaging;

(3) the donation is accompanied by a drug repository donor form described under paragraph (d) that is signed by an individual who is authorized by the donor to attest to the donor's knowledge in accordance with paragraph (d); and

(4) if the supply bears an expiration date, the date is at least six months later than the date the supply was donated. If the donated supply bears an expiration date that is less than six months from the date the supply was donated, the supply may be accepted and distributed if the supply is in high demand and can be dispensed for use by a patient before the supply's expiration date.

(d) The board shall develop the drug repository donor form and make it available on the board's website. The form must state that to the best of the donor's knowledge the donated drug or supply has been properly stored under appropriate temperature and humidity conditions, and that the drug or supply has never been opened, used, tampered with, adulterated, or misbranded.

(e) Donated drugs and supplies may be shipped or delivered to the premises of the central repository or a local repository, and shall be inspected by a pharmacist or an authorized practitioner who is employed by or under contract with the repository and who has been designated by the repository to accept donations. A drop box must not be used to deliver or accept donations.

(f) The central repository and local repository shall inventory all drugs and supplies donated to the repository. For each drug, the inventory must include the drug's name, strength, quantity, manufacturer, expiration date, and the date the drug was donated. For each medical supply, the inventory must include a description of the supply, its manufacturer, the date the supply was donated, and, if applicable, the supply's brand name and expiration date.

Subd. 7. **Standards and procedures for inspecting and storing donated prescription drugs and supplies.** (a) A pharmacist or authorized practitioner who is employed by or under contract with the central repository or a local repository shall inspect all donated prescription drugs and supplies before the drug or supply is dispensed to determine, to the extent reasonably possible in the professional judgment of the pharmacist or practitioner, that the drug or supply is not adulterated or misbranded, has not been tampered with, is safe and suitable for dispensing, has not been subject to a recall, and meets the requirements for donation. The pharmacist or practitioner who inspects the drugs or supplies shall sign an inspection record stating that the requirements for donation have been met. If a local repository receives drugs and supplies from the central repository, the local repository does not need to reinspect the drugs and supplies.

(b) The central repository and local repositories shall store donated drugs and supplies in a secure storage area under environmental conditions appropriate for the drug or supply being stored. Donated drugs and supplies may not be stored with nondonated inventory. If donated drugs or supplies are not inspected immediately upon receipt, a repository must quarantine the donated drugs or supplies separately from all dispensing stock until the donated drugs or supplies have been inspected and (1) approved for dispensing under the program; (2) disposed of pursuant to paragraph (c); or (3) returned to the donor pursuant to paragraph (d).

(c) The central repository and local repositories shall dispose of all prescription drugs and medical supplies that are not suitable for donation in compliance with applicable federal and state statutes, regulations, and rules concerning hazardous waste.

(d) In the event that controlled substances or prescription drugs that can only be dispensed to a patient registered with the drug's manufacturer are shipped or delivered to a central or local repository for donation, the shipment delivery must be documented by the repository and returned immediately to the donor or the donor's representative that provided the drugs.

(e) Each repository must develop drug and medical supply recall policies and procedures. If a repository receives a recall notification, the repository shall destroy all of the drug or medical supply in its inventory that is the subject of the recall and complete a record of destruction form in accordance with paragraph (f). If a drug or medical supply that is the subject of a Class I or Class II recall has been dispensed, the repository shall immediately notify the recipient of the recalled drug or medical supply. A drug that potentially is subject to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

(f) A record of destruction of donated drugs and supplies that are not dispensed under subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation shall be maintained by the repository for at least five years. For each drug or supply destroyed, the record shall include the following information:

(1) the date of destruction;

(2) the name, strength, and quantity of the drug destroyed; and

(3) the name of the person or firm that destroyed the drug.

Subd. 8. **Dispensing requirements.** (a) Donated drugs and supplies may be dispensed if the drugs or supplies are prescribed by a practitioner for use by an eligible individual and are dispensed by a pharmacist or practitioner. A repository shall dispense drugs and supplies

to eligible individuals in the following priority order: (1) individuals who are uninsured; (2) individuals with no prescription drug coverage; and (3) individuals who are underinsured. A repository shall dispense donated prescription drugs in compliance with applicable federal and state laws and regulations for dispensing prescription drugs, including all requirements relating to packaging, labeling, record keeping, drug utilization review, and patient counseling.

(b) Before dispensing or administering a drug or supply, the pharmacist or practitioner shall visually inspect the drug or supply for adulteration, misbranding, tampering, and date of expiration. Drugs or supplies that have expired or appear upon visual inspection to be adulterated, misbranded, or tampered with in any way must not be dispensed or administered.

(c) Before a drug or supply is dispensed or administered to an individual, the individual must sign a drug repository recipient form acknowledging that the individual understands the information stated on the form. The board shall develop the form and make it available on the board's website. The form must include the following information:

(1) that the drug or supply being dispensed or administered has been donated and may have been previously dispensed;

(2) that a visual inspection has been conducted by the pharmacist or practitioner to ensure that the drug or supply has not expired, has not been adulterated or misbranded, and is in its original, unopened packaging; and

(3) that the dispensing pharmacist, the dispensing or administering practitioner, the central repository or local repository, the Board of Pharmacy, and any other participant of the drug repository program cannot guarantee the safety of the drug or medical supply being dispensed or administered and that the pharmacist or practitioner has determined that the drug or supply is safe to dispense or administer based on the accuracy of the donor's form submitted with the donated drug or medical supply and the visual inspection required to be performed by the pharmacist or practitioner before dispensing or administering.

Subd. 9. **Handling fees.** (a) The central or local repository may charge the individual receiving a drug or supply a handling fee of no more than 250 percent of the medical assistance program dispensing fee for each drug or medical supply dispensed or administered by that repository.

(b) A repository that dispenses or administers a drug or medical supply through the drug repository program shall not receive reimbursement under the medical assistance program or the MinnesotaCare program for that dispensed or administered drug or supply.

Subd. 10. **Distribution of donated drugs and supplies.** (a) The central repository and local repositories may distribute drugs and supplies donated under the drug repository program to other participating repositories for use pursuant to this program.

(b) A local repository that elects not to dispense donated drugs or supplies must transfer all donated drugs and supplies to the central repository. A copy of the donor form that was completed by the original donor under subdivision 6 must be provided to the central repository at the time of transfer.

Subd. 11. **Forms and record-keeping requirements.** (a) The following forms developed for the administration of this program shall be utilized by the participants of the program and shall be available on the board's website:

(1) intake application form described under subdivision 5;

(2) local repository participation form described under subdivision 4;

(3) local repository withdrawal form described under subdivision 4;

(4) drug repository donor form described under subdivision 6;

(5) record of destruction form described under subdivision 7; and

(6) drug repository recipient form described under subdivision 8.

(b) All records, including drug inventory, inspection, and disposal of donated prescription drugs and medical supplies must be maintained by a repository for a minimum of five years. Records required as part of this program must be maintained pursuant to all applicable practice acts.

(c) Data collected by the drug repository program from all local repositories shall be submitted quarterly or upon request to the central repository. Data collected may consist of the information, records, and forms required to be collected under this section.

(d) The central repository shall submit reports to the board as required by the contract or upon request of the board.

Subd. 12. **Liability.** (a) The manufacturer of a drug or supply is not subject to criminal or civil liability for injury, death, or loss to a person or to property for causes of action described in clauses (1) and (2). A manufacturer is not liable for:

(1) the intentional or unintentional alteration of the drug or supply by a party not under the control of the manufacturer; or

(2) the failure of a party not under the control of the manufacturer to transfer or communicate product or consumer information or the expiration date of the donated drug or supply.

(b) A health care facility participating in the program, a pharmacist dispensing a drug or supply pursuant to the program, a practitioner dispensing or administering a drug or supply pursuant to the program, or a donor of a drug or medical supply is immune from civil liability for an act or omission that causes injury to or the death of an individual to whom the drug or supply is dispensed and no disciplinary action by a health-related licensing board shall be taken against a pharmacist or practitioner so long as the drug or supply is donated, accepted, distributed, and dispensed according to the requirements of this section. This immunity does not apply if the act or omission involves reckless, wanton, or intentional misconduct, or malpractice unrelated to the quality of the drug or medical supply.

Subd. 13. **Drug returned for credit.** Nothing in this section allows a long-term care facility to donate a drug to a central or local repository when federal or state law requires the drug to be returned to the pharmacy that initially dispensed it, so that the pharmacy can credit the payer for the amount of the drug returned.

Sec. 33. **[151.80] PRESCRIPTION DRUG PRICE TRANSPARENCY ACT.**

Sections 151.80 to 151.83 shall be known as the "Prescription Drug Price Transparency Act."

Sec. 34. **[151.81] DEFINITIONS.**

Subdivision 1. **Applicability.** Only for purposes of sections 151.80 to 151.83, the terms defined in this section have the meanings given.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 3. **New prescription drug.** "New prescription drug" means a prescription drug approved for marketing by the United States Food and Drug Administration (FDA) for which no previous wholesale acquisition cost has been established for comparison.

Subd. 4. **Patient assistance program or program.** "Patient assistance program" or "program" means a program that a manufacturer offers to the general public in which a consumer may reduce the out-of-pocket costs for prescription drugs paid by the consumer by using coupons, discount cards, prepaid gift cards, manufacturer debit cards, or other reduction in out-of-pocket costs by other means.

Subd. 5. **Prescription drug.** "Prescription drug" has the meaning provided in section 151.44, paragraph (d).

Subd. 6. **Price.** "Price" means the wholesale acquisition cost as defined in United States Code, title 42, section 1395w-3a(c)(6)(B).

Subd. 7. **Profit.** "Profit" means the total sales revenue for a prescription drug during the previous calendar year and the manufacturer's profit attributable to the same prescription drug during the previous calendar year.

Sec. 35. **[151.83] REPORTING PRESCRIPTION DRUG PRICES.**

Subdivision 1. **Applicability.** Beginning October 1, 2019, a manufacturer shall report the information described in subdivisions 2, 3, and 4 to the commissioner according to the requirements in subdivision 2, 3, or 4 as applicable.

Subd. 2. **Prescription drug price increases reporting.** For every prescription drug priced more than $40 for a course of therapy, whose price increases by more than ten percent in a 12-month period or more than 16 percent in a 24-month period, the manufacturer shall report to the commissioner at least 60 days in advance of the increase, in the form and manner prescribed by the commissioner, the following information in a form and format the commissioner has determined is appropriate for public display:

(1) the wholesale acquisition cost of the drug for each of the last five calendar years, as applicable;

(2) the price increase as a percentage of the drug's price for each of the last five calendar years, as applicable;

(3) the price of the drug at its initial launch;

(4) the factors that contributed to the price increase;

(5) the introductory price of the prescription drug when it was approved for marketing by the FDA;

(6) the direct costs incurred by the manufacturer that are associated with the drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs;

(iii) to research and develop the prescription drug;

(iv) to distribute the prescription drug;

(v) other administrative costs; and

(vi) profit;

(7) the percentage of the price spent on developing, manufacturing, and distributing the drug;

(8) a description of the change or improvement in the drug, if any, that necessitates the price increase;

(9) the total amount of financial assistance that the manufacturer has provided through any patient prescription assistance program;

(10) any agreement between a manufacturer and another party contingent upon any delay in offering to market a generic version of the manufacturer's drug;

(11) the patent expiration date of the drug if it is under patent;

(12) the research and development costs associated with the prescription drug that were paid using public funds;

(13) any other information that the manufacturer deems relevant to the price increase described in this subdivision; and

(14) the documentation necessary to support the information reported under this subdivision.

Subd. 3. **New prescription drug price reporting.** For every new prescription drug that is a brand name drug that is priced over $500 for a 30-day supply or a generic name drug that is priced over $200 for a 30-day supply, 60 days or less after a manufacturer introduces a new prescription drug for sale in the United States, the manufacturer shall notify the commissioner, in the form and manner prescribed by the commissioner, of all the following information in a form and format the commissioner has determined is appropriate for public display:

(1) the wholesale acquisition cost of the drug;

(2) the price of the drug at its initial launch;

(3) the factors that contributed to the price;

(4) the direct costs incurred by the manufacturer that are associated with that drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs;

(iii) to research and develop the prescription drug;

(iv) to distribute the prescription drug;

(v) other administrative costs; and

(vi) profit;

(5) the percentage of the price spent on developing, manufacturing, and distributing the drug;

(6) the total amount of financial assistance that the manufacturer has provided through any patient prescription assistance program;

(7) any agreement between a manufacturer and another party contingent upon any delay in offering to market a generic version of the manufacturer's drug;

(8) the patent expiration date of the drug if it is under patent;

(9) the research and development costs associated with the prescription drug that were paid using public funds;

(10) any other information that the manufacturer deems relevant to the price described in this subdivision; and

(11) the documentation necessary to support the information reported under this subdivision.

Subd. 4. **Newly acquired prescription drug price reporting.** For every newly acquired prescription drug that is a brand name drug that is priced over $100 for a 30-day supply or a generic name drug that is priced over $50 for a 30-day supply, the acquiring manufacturer shall report to the commissioner at least 60 days in advance of the acquisition, in the form and manner prescribed by the commissioner, the following information in a form and format the commissioner has determined is appropriate for public display:

(1) the wholesale acquisition cost at the time of acquisition and in the calendar year prior to acquisition;

(2) the name of the company from which the drug was acquired, the date acquired, and the purchase price;

(3) the year the drug was introduced to market and the wholesale acquisition cost of the drug at the time of introduction;

(4) the previous five calendar years' wholesale acquisition cost of the newly acquired brand name drug or newly acquired generic name drug;

(5) the direct costs incurred by the manufacturer that are associated with the drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs;

(iii) to research and develop the prescription drug;

(iv) to distribute the prescription drug;

(v) other administrative costs; and

(vi) profit;

(6) the percentage of the price projected to be spent on developing, manufacturing, and distributing the drug;

(7) the total amount of financial assistance that the manufacturer has provided through any patient prescription assistance program;

(8) any agreement between a manufacturer and another party contingent upon any delay in offering to market a generic version of the manufacturer's drug;

(9) the patent expiration date of the drug if it is under patent;

(10) the research and development costs associated with the prescription drug that were paid using public funds; and

(11) if available, the price as determined reasonable through effectiveness measures.

Subd. 5. **Comparison data.** The commissioner may use any publicly available prescription drug price information the commissioner deems appropriate to verify that manufacturers have properly reported price increases as required by subdivision 2 of this section.

Subd. 6. **Additional information requested.** After receiving the report or information described in subdivision 2, 3, 4, or 5, the commissioner may make a written request to the manufacturer for supporting documentation or additional information concerning the report.

Subd. 7. **Public posting of prescription drug price information.** (a) Except as provided in paragraph (c), the commissioner shall post to the department's website 30 days before a price change is effective the information from the manufacturer, in an easy-to-read format, that includes all of the following information:

(1) a list of the prescription drugs reported under subdivisions 2, 3, and 4 and the manufacturers of those prescription drugs; and

(2) information reported to the commissioner under subdivisions 2 to 6.

The information shall be published in a manner that identifies the information that is disclosed on a per-drug basis and shall not be aggregated in a manner that would not allow for identification of the drug.

(b) The commissioner may not post to the department's website any information described in this section if:

(1) the information is not public data under section 13.02, subdivision 8a; and

(2) the commissioner determines that public interest does not require disclosure of the information that is unrelated to the price of a prescription drug.

(c) The commissioner shall publicly announce the posting of information required under paragraph (a) and shall allow the public to comment on the posted information for a minimum of 30 calendar days.

(d) If the commissioner withholds any information from public disclosure pursuant to this subdivision, the commissioner shall post to the department's website a report describing the nature of the information and the commissioner's basis for withholding the information from disclosure.

Subd. 8. **Consultation.** The commissioner may consult with a nonprofit dedicated to collecting and reporting health care data and the commissioner of commerce, as appropriate, in issuing the form and format of the information reported under this section in posting information on the department's website pursuant to subdivision 7, and in taking any other action for the purpose of implementing this section.

Subd. 9. **Legislative report.** (a) No later than January 15, 2021, and annually on January 15 every year thereafter, the commissioner shall report to the chairs and ranking members of the committees with jurisdiction over commerce, health and human services, and state finance and operations on the implementation of the Prescription Drug Price Transparency Act, including but not limited to the effectiveness in addressing the following goals:

(1) promoting transparency in pharmaceutical pricing for the state and other payers;

(2) enhancing understanding about pharmaceutical spending trends; and

(3) assisting the state and other payers in management of pharmaceutical costs.

(b) The report shall include a summary of the information reported to the commissioner under subdivisions 2 to 7 as well as a summary of any public comments received.

(c) The report shall include recommendations for legislative changes, if any, to reduce the cost of prescription drugs and reduce the impact of price increases on consumers, the Department of Corrections, the State Employee Group Insurance Program, the Department of Human Services, and health insurance premiums in the fully insured markets.

Sec. 36. **[151.84] ENFORCEMENT AND PENALTIES.**

Subdivision 1. **Civil monetary penalties.** A manufacturer may be subject to a civil penalty, as provided in subdivision 2, for:

(1) failing to submit timely reports or notices as required by section 151.83;

(2) failing to provide information required under section 151.83;

(3) failing to respond in a timely manner to a written request by the commissioner for additional information under section 151.83, subdivision 6; or

(4) providing inaccurate or incomplete information under section 151.83.

Subd. 2. **Enforcement.** (a) A manufacturer that fails to report or provide information as required by section 151.83 may be subject to a civil penalty as provided in this section.

(b) The commissioner shall adopt a schedule of penalties, not to exceed $10,000 per day of violation, based on the severity of each violation.

(c) The commissioner shall impose civil penalties under this section as provided in section 144.99, subdivision 4.

(d) The commissioner may remit or mitigate civil penalties under this section upon terms and conditions the commissioner considers proper and consistent with public health and safety.

(e) Civil penalties collected under this section shall be paid to the commissioner of management and budget and deposited in the health care access fund to be made available for people served by state public health care programs.

Sec. 37. **[256.937] INSULIN ASSISTANCE PROGRAM.**

Subdivision 1. **Establishment.** (a) The commissioner of human services shall implement an insulin assistance program by July 1, 2020. Under the program, the commissioner shall:

(1) pay participating pharmacies for insulin that is dispensed by a participating pharmacy to an eligible individual subject to a valid prescription; and

(2) ensure pharmacy participation in the program in all areas of the state and maintain an up-to-date list of participating pharmacies on the department's website.

(b) The commissioner may contract with a private entity or enter into an interagency agreement with another state agency to implement this program.

Subd. 2. **Eligible individual.** (a) To be eligible for the insulin assistance program, an individual must submit to the commissioner an application form that is signed by the individual. To be eligible, an individual must:

(1) be a resident of Minnesota;

(2) not be eligible for Medicare, medical assistance, or MinnesotaCare;

(3) have a family income that is equal to or less than 400 percent of the federal poverty guidelines; and

(4) be uninsured, have no prescription drug coverage, or be covered by an individual or group health plan with an out-of-pocket limit of $5,000 or greater.

Eligibility for the insulin assistance program is subject to the limits of available funding.

(b) The commissioner shall develop an application form and make the form available to pharmacies, health care providers, and to individuals on the department's website. An applicant must include their income and insurance status information with the application. The commissioner may require the applicant to submit additional information to verify eligibility if deemed necessary by the commissioner.

(c) Upon receipt of a completed application and any additional information requested by the commissioner, the commissioner shall determine eligibility to the program. Once the individual has been determined eligible, the individual shall be issued an identification card. The card shall be valid for 90 days from the date of issuance and may be used at any participating pharmacy. An individual is not eligible for renewal until 12 months from the card's expiration date, at which time the individual must submit a new application form and meet the qualifications in paragraph (a).

Subd. 3. **Pharmacy participation.** (a) Pharmacy participation in the program is voluntary. In order to participate, a pharmacy must register with the commissioner and agree to reimbursement and other contract terms. A pharmacy may withdraw from participation at any time by providing written notice to the commissioner.

(b) A pharmacy shall dispense insulin to eligible individuals who present a valid prescription and an identification card.

(c) Eligible individuals are responsible for paying an insulin co-payment to the participating pharmacy that is equal to the prescription co-payment required under section 256L.03, subdivision 5.

(d) Notwithstanding paragraph (c), if an eligible individual has coverage through an individual or group health plan, the pharmacy must process the insulin in accordance with the individual's health plan.

(e) When dispensing insulin to an eligible individual, a pharmacy must provide the individual with the address for the website established under section 151.06, subdivision 6, paragraph (a).

Sec. 38. **[256.938] INSULIN ASSISTANCE ACCOUNT.**

Subdivision 1. **Establishment.** The insulin assistance account is established in the special revenue fund in the state treasury. The fees collected by the Board of Pharmacy under section 151.252, subdivision 1, paragraph (b), shall be deposited into the account.

Subd. 2. **Use of account funds.** For fiscal year 2021 and subsequent fiscal years, money in the insulin assistance account is appropriated to the commissioner of human services to fund the insulin assistance program established under section 256.937.

Sec. 39. Minnesota Statutes 2018, section 256B.69, subdivision 6, is amended to read:

Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for the health care coordination for eligible individuals. Demonstration providers:

(1) shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to enrollees. Notwithstanding section 256B.0621, demonstration providers that provide nursing home and community-based services under this section shall provide relocation service coordination to enrolled persons age 65 and over;

(2) shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees; and

(4) shall institute recipient grievance procedures according to the method established by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved through this process shall be appealable to the commissioner as provided in subdivision 11.

(b) Demonstration providers must comply with the standards for claims settlement under section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and social service practitioners to provide services to enrollees. A demonstration provider must pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b), within 30 business days of the date of acceptance of the claim.

(c) Managed care plans and county-based purchasing plans must comply with section 62Q.83.

Sec. 40. **SEVERABILITY.**

If any provision of the amendments to Minnesota Statutes, sections 62Q.83, 62W.01 to 62W.13, and 151.21, subdivisions 7 and 7a, are held invalid or unenforceable, the remainder of the sections are not affected and the provisions of the sections are severable.

Sec. 41. **CITATION.**

The amendments to Minnesota Statutes, sections 147.37, 148.192, 151.06, subdivision 6, 151.252, subdivision 1, 151.254, 256.937, and 256.938, may be cited as "The Alec Smith Emergency Insulin Act."

Sec. 42. **REPEALER.**

Minnesota Statutes 2018, sections 151.214, subdivision 2; 151.60; 151.61; 151.62; 151.63; 151.64; 151.65; 151.66; 151.67; 151.68; 151.69; 151.70; and 151.71, are repealed.

## ARTICLE 11
## HEALTH-RELATED LICENSING BOARDS

Section 1. **[144A.291] FEES.**

Subdivision 1. **Nonrefundable fees.** All fees are nonrefundable.

Subd. 2. **Amounts.** (a) Fees may not exceed the following amounts but may be adjusted lower by board direction and are for the exclusive use of the board as required to sustain board operations. The maximum amounts of fees are:

(1) application for licensure, $200;

(2) for a prospective applicant for a review of education and experience advisory to the license application, $100, to be applied to the fee for application for licensure if the latter is submitted within one year of the request for review of education and experience;

(3) state examination, $125;

(4) initial license, $250 if issued between July 1 and December 31, $100 if issued between January 1 and June 30;

(5) acting administrator permit, $400;

(6) renewal license, $250;

(7) duplicate license, $50;

(8) reinstatement fee, $250;

(9) health services executive initial license, $200;

(10) health services executive renewal license, $200;

(11) reciprocity verification fee, $50;

(12) second shared administrator assignment, $250;

(13) continuing education fees:

(i) greater than 6 hours, $50; and

(ii) 7 hours or more, $75;

(14) education review, $100;

(15) fee to a sponsor for review of individual continuing education seminars, institutes, workshops, or home study courses:

(i) for less than seven clock hours, $30; and

(ii) for seven or more clock hours, $50;

(16) fee to a licensee for review of continuing education seminars, institutes, workshops, or home study courses not previously approved for a sponsor and submitted with an application for license renewal:

(i) for less than seven clock hours total, $30; and

(ii) for seven or more clock hours total, $50;

(17) late renewal fee, $75;

(18) fee to a licensee for verification of licensure status and examination scores, $30;

(19) registration as a registered continuing education sponsor, $1,000; and

(20) mail labels, $75.

(b) The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

Sec. 2. Minnesota Statutes 2018, section 147D.27, is amended by adding a subdivision to read:

Subd. 5. **Additional fees.** (a) The following fees also apply:

(1) traditional midwifery annual registration fee, $100;

(2) traditional midwifery application fee, $100;

(3) traditional midwifery late fee, $75;

(4) traditional midwifery inactive status, $50;

(5) traditional midwifery temporary permit, $75;

(6) traditional midwifery certification fee, $25;

(7) duplicate license or registration fee, $20;

(8) certification letter, $25;

(9) education or training program approval fee, $100; and

(10) report creation and generation, $60 per hour billed in quarter-hour increments with a quarter-hour minimum.

(b) The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 3. Minnesota Statutes 2018, section 147E.40, subdivision 1, is amended to read:

Subdivision 1. **Fees.** (a) Fees are as follows:

(1) registration application fee, $200;

(2) renewal fee, $150;

(3) late fee, $75;

(4) inactive status fee, $50; ~~and~~

(5) temporary permit fee, $25~~.~~;

(6) naturopathic doctor certification fee, $25;

(7) naturopathic doctor duplicate license fee, $20;

(8) naturopathic doctor emeritus registration fee, $50;

(9) naturopathic doctor certification fee, $25;

(10) duplicate license or registration fee, $20;

(11) education or training program approval fee, $100; and

(12) report creation and generation, $60 per hour billed in quarter-hour increments with a quarter-hour minimum.

(b) The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 4. Minnesota Statutes 2018, section 147F.17, subdivision 1, is amended to read:

Subdivision 1. **Fees.** (a) Fees are as follows:

(1) license application fee, $200;

(2) initial licensure and annual renewal, $150; ~~and~~

(3) late fee, $75~~.~~;

(4) genetic counselor certification fee, $25;

(5) duplicate license fee, $20;

(6) education or training program approval fee, $100; and

(7) report creation and generation, $60 per hour billed in quarter-hour increments with a quarter-hour minimum.

(b) The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 5. Minnesota Statutes 2018, section 148.59, is amended to read:

**148.59 LICENSE RENEWAL; LICENSE AND REGISTRATION FEES.**

A licensed optometrist shall pay to the state Board of Optometry a fee as set by the board in order to renew a license as provided by board rule. No fees shall be refunded. Fees may not exceed the following amounts but may be adjusted lower by board direction and are for the exclusive use of the board:

(1) optometry licensure application, $160;

(2) optometry annual licensure renewal, ~~$135~~ $200;

(3) optometry late penalty fee, $75;

(4) annual license renewal card, $10;

(5) continuing education provider application, $45;

(6) emeritus registration, $10;

(7) endorsement/reciprocity application, $160;

(8) replacement of initial license, $12; ~~and~~

(9) license verification, $50~~.~~;

(10) state juris prudence examination, $75; and

(11) miscellaneous labels and data retrieval, $50.

Sec. 6. Minnesota Statutes 2018, section 148.6445, subdivision 1, is amended to read:

Subdivision 1. **Initial licensure fee.** The initial licensure fee for occupational therapists is ~~$145~~ $185. The initial licensure fee for occupational therapy assistants is ~~$80~~ $105. ~~The board shall prorate fees based on the number of quarters remaining in the biennial licensure period.~~

Sec. 7. Minnesota Statutes 2018, section 148.6445, subdivision 2, is amended to read:

Subd. 2. **Licensure renewal fee.** The biennial licensure renewal fee for occupational therapists is ~~$145~~ $185. The biennial licensure renewal fee for occupational therapy assistants is ~~$80~~ $105.

Sec. 8. Minnesota Statutes 2018, section 148.6445, subdivision 2a, is amended to read:

Subd. 2a. **Duplicate license fee.** The fee for a duplicate license is ~~$25~~ $30.

Sec. 9. Minnesota Statutes 2018, section 148.6445, subdivision 3, is amended to read:

Subd. 3. **Late fee.** The fee for late submission of a renewal application is ~~$25~~ $50.

Sec. 10. Minnesota Statutes 2018, section 148.6445, subdivision 4, is amended to read:

Subd. 4. **Temporary licensure fee.** The fee for temporary licensure is ~~$50~~ $75.

Sec. 11. Minnesota Statutes 2018, section 148.6445, subdivision 5, is amended to read:

Subd. 5. **Limited licensure fee.** The fee for limited licensure is ~~$96~~ $100.

Sec. 12. Minnesota Statutes 2018, section 148.6445, subdivision 6, is amended to read:

Subd. 6. **Fee for course approval after lapse of licensure.** The fee for course approval after lapse of licensure is ~~$96~~ $100.

Sec. 13. Minnesota Statutes 2018, section 148.6445, subdivision 10, is amended to read:

Subd. 10. **Use of fees.** (a) All fees are nonrefundable. The board shall only use fees collected under this section for the purposes of administering this chapter. The legislature must not transfer money generated by these fees from the state government special revenue fund to the general fund.

(b) Licensure fees are for the exclusive use of the board and shall be established by the board not to exceed the nonrefundable amounts in this section.

Sec. 14. Minnesota Statutes 2018, section 148.7815, subdivision 1, is amended to read:

Subdivision 1. **Fees.** (a) The board shall establish fees as follows:

(1) application fee, $50; ~~and~~

(2) annual license fee, $100~~.~~;

(3) athletic trainer certification fee, $25;

(4) athletic trainer duplicate license fee, $20;

(5) duplicate license or registration fee, $20;

(6) education or training program approval fee, $100;

(7) report creation and generation, $60 per hour billed in quarter-hour increments with a quarter-hour minimum; and

(8) examination administrative fee:

(i) half day, $50; and

(ii) full day, $80.

(b) The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 15. **[148.981] FEES.**

Subdivision 1. **Licensing fees.** The nonrefundable fees for licensure shall be established by the board, not to exceed the following amounts:

(1) application for admission to national standardized examination, $150;

(2) application for professional responsibility examination, $150;

(3) application for licensure as a licensed psychologist, $500;

(4) renewal of license for a licensed psychologist, $500;

(5) late renewal of license for a licensed psychologist, $250;

(6) application for converting from master's to doctoral level licensure, $150;

(7) application for guest licensure, $150;

(8) certificate replacement fee, $25;

(9) mailing and duplication fee, $5;

(10) statute and rule book fee, $10;

(11) verification fee, $20; and

(12) fee for optional preapproval of postdoctoral supervision, $50.

Subd. 2. **Continuing education sponsor fee.** A sponsor applying for approval of a continuing education activity pursuant to Minnesota Rules, part 7200.3830, subpart 2, shall submit with the application a fee to be established by the board, not to exceed $80 for each activity.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 16. Minnesota Statutes 2018, section 148E.180, is amended to read:

**148E.180 FEE AMOUNTS.**

Subdivision 1. **Application fees.** Nonrefundable application fees for licensure ~~are as follows~~ may not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, ~~$45~~ $75;

(2) for a licensed graduate social worker, ~~$45~~ $75;

(3) for a licensed independent social worker, ~~$45~~ $75;

(4) for a licensed independent clinical social worker, ~~$45~~ $75;

(5) for a temporary license, $50; and

(6) for a ~~licensure~~ license by endorsement, ~~$85~~ $115.

The fee for criminal background checks is the fee charged by the Bureau of Criminal Apprehension. The criminal background check fee must be included with the application fee as required according to section 148E.055.

Subd. 2. **License fees.** Nonrefundable license fees ~~are as follows~~ may not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, ~~$81~~ $115;

(2) for a licensed graduate social worker, ~~$144~~ $210;

(3) for a licensed independent social worker, ~~$216~~ $305;

(4) for a licensed independent clinical social worker, ~~$238.50~~ $335;

(5) for an emeritus inactive license, ~~$43.20~~ $65;

(6) for an emeritus active license, one-half of the renewal fee specified in subdivision 3; and

(7) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

If the licensee's initial license term is less or more than 24 months, the required license fees must be prorated proportionately.

Subd. 3. **Renewal fees.** Nonrefundable renewal fees for licensure ~~are as follows~~ may not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, ~~$81~~ $115;

(2) for a licensed graduate social worker, ~~$144~~ $210;

(3) for a licensed independent social worker, ~~$216~~ $305; and

(4) for a licensed independent clinical social worker, ~~$238.50~~ $335.

Subd. 4. **Continuing education provider fees.** Continuing education provider fees are ~~as follows~~ the following nonrefundable amounts:

(1) for a provider who offers programs totaling one to eight clock hours in a one-year period according to section 148E.145, $50;

(2) for a provider who offers programs totaling nine to 16 clock hours in a one-year period according to section 148E.145, $100;

(3) for a provider who offers programs totaling 17 to 32 clock hours in a one-year period according to section 148E.145, $200;

(4) for a provider who offers programs totaling 33 to 48 clock hours in a one-year period according to section 148E.145, $400; and

(5) for a provider who offers programs totaling 49 or more clock hours in a one-year period according to section 148E.145, $600.

Subd. 5. **Late fees.** Late fees are ~~as follows~~ the following nonrefundable amounts:

(1) renewal late fee, one-fourth of the renewal fee specified in subdivision 3;

(2) supervision plan late fee, $40; and

(3) license late fee, $100 plus the prorated share of the license fee specified in subdivision 2 for the number of months during which the individual practiced social work without a license.

Subd. 6. **License cards and wall certificates.** (a) The nonrefundable fee for a license card as specified in section 148E.095 is $10.

(b) The nonrefundable fee for a license wall certificate as specified in section 148E.095 is $30.

Subd. 7. **Reactivation fees.** Reactivation fees are ~~as follows~~ the following nonrefundable amounts:

(1) reactivation from a temporary leave or emeritus status, the prorated share of the renewal fee specified in subdivision 3; and

(2) reactivation of an expired license, 1-1/2 times the renewal fees specified in subdivision 3.

Sec. 17. Minnesota Statutes 2018, section 150A.06, is amended by adding a subdivision to read:

Subd. 10. **Emeritus inactive license.** A person licensed to practice dentistry, dental therapy, dental hygiene, or dental assisting pursuant to section 150A.05 or Minnesota Rules, part 3100.8500, who retires from active practice in the state may apply to the board for emeritus inactive licensure. An application for emeritus inactive licensure may be made on the biennial licensing form or by petitioning the board, and the applicant must pay a onetime application fee pursuant to section 150A.091, subdivision 19. In order to receive emeritus inactive licensure, the applicant must be in compliance with board requirements and cannot be the subject of current disciplinary action resulting in suspension, revocation, disqualification, condition, or restriction of the licensee to practice dentistry, dental therapy, dental hygiene, or dental assisting. An emeritus inactive license is not a license to practice, but is a formal recognition of completion of a person's dental career in good standing.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 18. Minnesota Statutes 2018, section 150A.06, is amended by adding a subdivision to read:

Subd. 11. **Emeritus active licensure.** (a) A person licensed to practice dentistry, dental therapy, dental hygiene, or dental assisting may apply for an emeritus active license if the person is retired from active practice, is in compliance with board requirements, and is not the subject of current disciplinary action resulting in suspension, revocation, disqualification, condition, or restriction of the license to practice dentistry, dental therapy, dental hygiene, or dental assisting.

(b) An emeritus active licensee may engage only in the following types of practice:

(1) pro bono or volunteer dental practice;

(2) paid practice not to exceed 500 hours per calendar year for the exclusive purpose of providing licensing supervision to meet the board's requirements; or

(3) paid consulting services not to exceed 500 hours per calendar year.

(c) An emeritus active licensee shall not hold out as a full licensee and may only hold out as authorized to practice as described in this subdivision. The board may take disciplinary or corrective action against an emeritus active licensee based on violations of applicable law or board requirements.

(d) A person may apply for an emeritus active license by completing an application form specified by the board and must pay the application fee pursuant to section 150A.091, subdivision 20.

(e) If an emeritus active license is not renewed every two years, the license expires. The renewal date is the same as the licensee's renewal date when the licensee was in active practice. In order to renew an emeritus active license, the licensee must:

(1) complete an application form as specified by the board;

(2) pay the required renewal fee pursuant to section 150A.091, subdivision 20; and

(3) report at least 25 continuing education hours completed since the last renewal, which must include:

(i) at least one hour in two different required CORE areas;

(ii) at least one hour of mandatory infection control;

(iii) for dentists and dental therapists, at least 15 hours of fundamental credits for dentists and dental therapists, and for dental hygienists and dental assistants, at least seven hours of fundamental credits; and

(iv) for dentists and dental therapists, no more than ten elective credits, and for dental hygienists and dental assistants, no more than six elective credits.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 19. Minnesota Statutes 2018, section 150A.091, is amended by adding a subdivision to read:

Subd. 19. **Emeritus inactive license.** An individual applying for emeritus inactive licensure under section 150A.06, subdivision 10, must pay a onetime fee of $50. There is no renewal fee for an emeritus inactive license.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 20. Minnesota Statutes 2018, section 150A.091, is amended by adding a subdivision to read:

Subd. 20. **Emeritus active license.** An individual applying for emeritus active licensure under section 150A.06, subdivision 11, must pay a fee upon application and upon renewal every two years. The fees for emeritus active license application and renewal are as follows: dentist, $212; dental therapist, $100; dental hygienist, $75; and dental assistant, $55.

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 21. Minnesota Statutes 2018, section 151.01, subdivision 31, is amended to read:

Subd. 31. **Central service pharmacy.** "Central service pharmacy" means a pharmacy that ~~may provide~~ performs those activities involved in the dispensing ~~functions,~~ of a drug ~~utilization review, packaging, labeling, or delivery of a prescription product to~~ for another pharmacy ~~for the purpose of filling a prescription~~, pursuant to the requirements of this chapter and the rules of the board.

Sec. 22. Minnesota Statutes 2018, section 151.01, subdivision 35, is amended to read:

Subd. 35. **Compounding.** "Compounding" means preparing, mixing, assembling, packaging, and labeling a drug for an identified individual patient as a result of a practitioner's prescription drug order. Compounding also includes anticipatory compounding, as defined in this section, and the preparation of drugs in which all bulk drug substances and components are nonprescription substances. Compounding does not include mixing or reconstituting a drug according to the product's labeling or to the manufacturer's directions, provided that such labeling has been approved by the United States Food and Drug Administration (FDA) or the manufacturer is licensed under section 151.252. Compounding does not include the preparation of a drug for the purpose of, or incident to, research, teaching, or chemical analysis, provided that the drug is not prepared for dispensing or administration to patients. All compounding, regardless of the type of product, must be done pursuant to a prescription drug order unless otherwise permitted in this chapter or by the rules of the board. Compounding does not include a minor deviation from such directions with regard to radioactivity, volume, or stability, which is made by or under the supervision of a licensed nuclear pharmacist or a physician, and which is necessary in order to accommodate circumstances not contemplated in the manufacturer's instructions, such as the rate of radioactive decay or geographical distance from the patient.

Sec. 23. Minnesota Statutes 2018, section 151.01, is amended by adding a subdivision to read:

Subd. 42. **Syringe services provider.** "Syringe services provider" means a public health program, registered with the commissioner of health, that provides cost-free comprehensive harm reduction services, including: sterile needles, syringes, and other injection equipment; safe disposal containers for needles and syringes; education about overdose prevention, safer injection practices, and infectious disease prevention; referral to or provision of blood

borne pathogen testing; referral to substance use disorder treatment, including medication-assisted treatment; and referral to medical, mental health, and social services.

Sec. 24. Minnesota Statutes 2018, section 151.065, subdivision 1, is amended to read:

Subdivision 1. **Application fees.** Application fees for licensure and registration are as follows:

(1) pharmacist licensed by examination, ~~$145~~ $175;

(2) pharmacist licensed by reciprocity, ~~$240~~ $275;

(3) pharmacy intern, ~~$37.50~~ $50;

(4) pharmacy technician, ~~$37.50~~ $50;

(5) pharmacy, ~~$225~~ $260;

(6) drug wholesaler, legend drugs only, ~~$235~~ $260;

(7) drug wholesaler, legend and nonlegend drugs, ~~$235~~ $260;

(8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~$210~~ $260;

(9) drug wholesaler, medical gases, ~~$175~~ $260;

(10) ~~drug wholesaler, also licensed as a pharmacy in Minnesota, $150~~ third-party logistics provider, $260;

(11) drug manufacturer, legend drugs only, ~~$235~~ $260;

(12) drug manufacturer, legend and nonlegend drugs, ~~$235~~ $260;

(13) drug manufacturer, nonlegend or veterinary legend drugs, ~~$210~~ $260;

(14) drug manufacturer, medical gases, ~~$185~~ $260;

(15) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~$150~~ $260;

(16) medical gas distributor, ~~$110~~ $260; and

~~(17) controlled substance researcher, $75; and~~

~~(18)~~ (17) pharmacy professional corporation, ~~$125~~ $150.

Sec. 25. Minnesota Statutes 2018, section 151.065, subdivision 2, is amended to read:

Subd. 2. **Original license fee.** The pharmacist original licensure fee, ~~$145~~ $175.

Sec. 26. Minnesota Statutes 2018, section 151.065, subdivision 3, is amended to read:

Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as follows:

(1) pharmacist, ~~$145~~ $175;

(2) pharmacy technician, ~~$37.50~~ $50;

(3) pharmacy, ~~$225~~ $260;

(4) drug wholesaler, legend drugs only, ~~$235~~ $260;

(5) drug wholesaler, legend and nonlegend drugs, ~~$235~~ $260;

(6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~$210~~ $260;

(7) drug wholesaler, medical gases, ~~$185~~ $260;

(8) ~~drug wholesaler, also licensed as a pharmacy in Minnesota, $150~~ third-party logistics provider, $260;

(9) drug manufacturer, legend drugs only, ~~$235~~ $260;

(10) drug manufacturer, legend and nonlegend drugs, ~~$235~~ $260;

(11) drug manufacturer, nonlegend, veterinary legend drugs, or both, ~~$210~~ $260;

(12) drug manufacturer, medical gases, ~~$185~~ $260;

(13) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~$150~~ $260;

(14) medical gas distributor, ~~$110~~ $260; and

~~(15) controlled substance researcher, $75; and~~

~~(16)~~ (15) pharmacy professional corporation, ~~$75~~ $100.

Sec. 27. Minnesota Statutes 2018, section 151.065, subdivision 6, is amended to read:

Subd. 6. **Reinstatement fees.** (a) A pharmacist who has allowed the pharmacist's license to lapse may reinstate the license with board approval and upon payment of any fees and late fees in arrears, up to a maximum of $1,000.

(b) A pharmacy technician who has allowed the technician's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears, up to a maximum of $90.

(c) An owner of a pharmacy, a drug wholesaler, a drug manufacturer, third-party logistics provider, or a medical gas distributor who has allowed the license of the establishment to

lapse may reinstate the license with board approval and upon payment of any fees and late fees in arrears.

(d) A controlled substance ~~researcher~~ registrant who has allowed ~~the researcher's~~ a registration issued pursuant to subdivision 4 to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears.

(e) A pharmacist owner of a professional corporation who has allowed the corporation's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears.

Sec. 28. Minnesota Statutes 2018, section 151.071, subdivision 2, is amended to read:

Subd. 2. **Grounds for disciplinary action.** The following conduct is prohibited and is grounds for disciplinary action:

(1) failure to demonstrate the qualifications or satisfy the requirements for a license or registration contained in this chapter or the rules of the board. The burden of proof is on the applicant to demonstrate such qualifications or satisfaction of such requirements;

(2) obtaining a license by fraud or by misleading the board in any way during the application process or obtaining a license by cheating, or attempting to subvert the licensing examination process. Conduct that subverts or attempts to subvert the licensing examination process includes, but is not limited to: (i) conduct that violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination; (ii) conduct that violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials; or (iii) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf;

(3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration, conviction of a felony reasonably related to the practice of pharmacy. Conviction as used in this subdivision includes a conviction of an offense that if committed in this state would be deemed a felony without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered thereon. The board may delay the issuance of a new license or

registration if the applicant has been charged with a felony until the matter has been adjudicated;

(4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner or applicant is convicted of a felony reasonably related to the operation of the facility. The board may delay the issuance of a new license or registration if the owner or applicant has been charged with a felony until the matter has been adjudicated;

(5) for a controlled substance researcher, conviction of a felony reasonably related to controlled substances or to the practice of the researcher's profession. The board may delay the issuance of a registration if the applicant has been charged with a felony until the matter has been adjudicated;

(6) disciplinary action taken by another state or by one of this state's health licensing agencies:

(i) revocation, suspension, restriction, limitation, or other disciplinary action against a license or registration in another state or jurisdiction, failure to report to the board that charges or allegations regarding the person's license or registration have been brought in another state or jurisdiction, or having been refused a license or registration by any other state or jurisdiction. The board may delay the issuance of a new license or registration if an investigation or disciplinary action is pending in another state or jurisdiction until the investigation or action has been dismissed or otherwise resolved; and

(ii) revocation, suspension, restriction, limitation, or other disciplinary action against a license or registration issued by another of this state's health licensing agencies, failure to report to the board that charges regarding the person's license or registration have been brought by another of this state's health licensing agencies, or having been refused a license or registration by another of this state's health licensing agencies. The board may delay the issuance of a new license or registration if a disciplinary action is pending before another of this state's health licensing agencies until the action has been dismissed or otherwise resolved;

(7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of any order of the board, of any of the provisions of this chapter or any rules of the board or violation of any federal, state, or local law or rule reasonably pertaining to the practice of pharmacy;

(8) for a facility, other than a pharmacy, licensed by the board, violations of any order of the board, of any of the provisions of this chapter or the rules of the board or violation of any federal, state, or local law relating to the operation of the facility;

(9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient; or pharmacy practice that is professionally incompetent, in that it may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established;

(10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy technician or pharmacist intern if that person is performing duties allowed by this chapter or the rules of the board;

(11) for an individual licensed or registered by the board, adjudication as mentally ill or developmentally disabled, or as a chemically dependent person, a person dangerous to the public, a sexually dangerous person, or a person who has a sexual psychopathic personality, by a court of competent jurisdiction, within or without this state. Such adjudication shall automatically suspend a license for the duration thereof unless the board orders otherwise;

(12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist intern or performing duties specifically reserved for pharmacists under this chapter or the rules of the board;

(13) for a pharmacy, operation of the pharmacy without a pharmacist present and on duty except as allowed by a variance approved by the board;

(14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety to patients by reason of illness, ~~drunkenness,~~ use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills. In the case of registered pharmacy technicians, pharmacist interns, or controlled substance researchers, the inability to carry out duties allowed under this chapter or the rules of the board with reasonable skill and safety to patients by reason of illness, ~~drunkenness,~~ use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills;

(15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas distributor, or controlled substance researcher, revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law;

(16) for a pharmacist or pharmacy, improper management of patient records, including failure to maintain adequate patient records, to comply with a patient's request made pursuant to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

(17) fee splitting, including without limitation:

(i) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate, kickback, or other form of remuneration, directly or indirectly, for the referral of patients; ~~and~~

(ii) referring a patient to any health care provider as defined in sections 144.291 to 144.298 in which the licensee or registrant has a financial or economic interest as defined in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the licensee's or registrant's financial or economic interest in accordance with section 144.6521; and

(iii) any arrangement through which a pharmacy, in which the prescribing practitioner does not have a significant ownership interest, fills a prescription drug order and the prescribing practitioner is involved in any manner, directly or indirectly, in setting the price for the filled prescription that is charged to the patient, the patient's insurer or pharmacy benefit manager, or other person paying for the prescription or, in the case of veterinary patients, the price for the filled prescription that is charged to the client or other person paying for the prescription, except that a veterinarian and a pharmacy may enter into such an arrangement provided that the client or other person paying for the prescription is notified, in writing and with each prescription dispensed, about the arrangement, unless such arrangement involves pharmacy services provided for livestock, poultry, and agricultural production systems, in which case client notification would not be required;

(18) engaging in abusive or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws or rules;

(19) engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient;

(20) failure to make reports as required by section 151.072 or to cooperate with an investigation of the board as required by section 151.074;

(21) knowingly providing false or misleading information that is directly related to the care of a patient unless done for an accepted therapeutic purpose such as the dispensing and administration of a placebo;

(22) aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

(i) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;

(ii) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;

(iii) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or

(iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board shall investigate any complaint of a violation of section 609.215, subdivision 1 or 2;

(23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For a pharmacist intern, pharmacy technician, or controlled substance researcher, performing duties permitted to such individuals by this chapter or the rules of the board under a lapsed or nonrenewed registration. For a facility required to be licensed under this chapter, operation of the facility under a lapsed or nonrenewed license or registration; and

(24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge from the health professionals services program for reasons other than the satisfactory completion of the program.

Sec. 29. Minnesota Statutes 2018, section 151.15, subdivision 1, is amended to read:

Subdivision 1. **Location.** It shall be unlawful for any person to compound~~,~~ or dispense~~, vend, or sell~~ drugs~~, medicines, chemicals, or poisons~~ in any place other than a pharmacy, except as provided in this chapter; except that a licensed pharmacist or pharmacist intern working within a licensed hospital may receive a prescription drug order and access the hospital's pharmacy prescription processing system through secure and encrypted electronic means in order to process the prescription drug order.

Sec. 30. Minnesota Statutes 2018, section 151.15, is amended by adding a subdivision to read:

Subd. 5. **Receipt of emergency prescription orders.** A pharmacist, when that pharmacist is not present within a licensed pharmacy, may accept a written, verbal, or electronic prescription drug order from a practitioner only if:

(1) the prescription drug order is for an emergency situation where waiting for the pharmacist to travel to a licensed pharmacy to accept the prescription drug order would likely cause the patient to experience significant physical harm or discomfort;

(2) the pharmacy from which the prescription drug order will be dispensed is closed for business;

(3) the pharmacist has been designated to be on call for the licensed pharmacy that will fill the prescription drug order;

(4) electronic prescription drug orders are received through secure and encrypted electronic means;

(5) the pharmacist takes reasonable precautions to ensure that the prescription drug order will be handled in a manner consistent with federal and state statutes regarding the handling of protected health information; and

(6) the pharmacy from which the prescription drug order will be dispensed has relevant and appropriate policies and procedures in place and makes them available to the board upon request.

Sec. 31. Minnesota Statutes 2018, section 151.15, is amended by adding a subdivision to read:

Subd. 6. **Processing of emergency prescription orders.** A pharmacist, when that pharmacist is not present within a licensed pharmacy, may access a pharmacy prescription processing system through secure and encrypted electronic means in order to process an emergency prescription accepted pursuant to subdivision 5 only if:

(1) the pharmacy from which the prescription drug order will be dispensed is closed for business;

(2) the pharmacist has been designated to be on call for the licensed pharmacy that will fill the prescription drug order;

(3) the prescription drug order is for a patient of a long-term care facility or a county correctional facility;

(4) the prescription drug order is not being processed pursuant to section 151.58;

(5) the prescription drug order is processed pursuant to this chapter and the rules promulgated thereunder; and

(6) the pharmacy from which the prescription drug order will be dispensed has relevant and appropriate policies and procedures in place and makes them available to the board upon request.

Sec. 32. Minnesota Statutes 2018, section 151.19, subdivision 1, is amended to read:

Subdivision 1. **Pharmacy licensure requirements.** (a) No person shall operate a pharmacy without first obtaining a license from the board and paying any applicable fee specified in section 151.065. The license shall be displayed in a conspicuous place in the pharmacy for which it is issued and expires on June 30 following the date of issue. It is unlawful for any person to operate a pharmacy unless the license has been issued to the person by the board.

(b) Application for a pharmacy license under this section shall be made in a manner specified by the board.

(c) No license shall be issued or renewed for a pharmacy located within the state unless the applicant agrees to operate the pharmacy in a manner prescribed by federal and state law and according to rules adopted by the board. No license shall be issued for a pharmacy located outside of the state unless the applicant agrees to operate the pharmacy in a manner prescribed by federal law and, when dispensing medications for residents of this state, the laws of this state, and Minnesota Rules.

(d) No license shall be issued or renewed for a pharmacy that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of such licensure or registration.

(e) The board shall require a separate license for each pharmacy located within the state and for each pharmacy located outside of the state at which any portion of the dispensing process occurs for drugs dispensed to residents of this state.

(f) ~~The board shall not issue~~ Prior to the issuance of an initial or renewed license for a pharmacy ~~unless~~, the board may require the pharmacy ~~passes~~ to pass an inspection conducted by an authorized representative of the board. In the case of a pharmacy located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may deny licensure unless the applicant submits

documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

(g) The board shall not issue an initial or renewed license for a pharmacy located outside of the state unless the applicant discloses and certifies:

(1) the location, names, and titles of all principal corporate officers and all pharmacists who are involved in dispensing drugs to residents of this state;

(2) that it maintains its records of drugs dispensed to residents of this state so that the records are readily retrievable from the records of other drugs dispensed;

(3) that it agrees to cooperate with, and provide information to, the board concerning matters related to dispensing drugs to residents of this state;

(4) that, during its regular hours of operation, but no less than six days per week, for a minimum of 40 hours per week, a toll-free telephone service is provided to facilitate communication between patients in this state and a pharmacist at the pharmacy who has access to the patients' records; the toll-free number must be disclosed on the label affixed to each container of drugs dispensed to residents of this state; and

(5) that, upon request of a resident of a long-term care facility located in this state, the resident's authorized representative, or a contract pharmacy or licensed health care facility acting on behalf of the resident, the pharmacy will dispense medications prescribed for the resident in unit-dose packaging or, alternatively, comply with section 151.415, subdivision 5.

(h) This subdivision does not apply to a manufacturer licensed under section 151.252, subdivision 1, a wholesale drug distributor licensed under section 151.47, or a third-party logistics provider, to the extent the manufacturer, wholesale drug distributor, or third-party logistics provider is engaged in the distribution of dialysate or devices necessary to perform home peritoneal dialysis on patients with end-stage renal disease, if:

(1) the manufacturer or its agent leases or owns the licensed manufacturing or wholesaling facility from which the dialysate or devices will be delivered;

(2) the dialysate is comprised of dextrose or icodextrin and has been approved by the United States Food and Drug Administration;

(3) the dialysate is stored and delivered in its original, sealed, and unopened manufacturer's packaging;

(4) the dialysate or devices are delivered only upon:

(i) receipt of a physician's order by a Minnesota licensed pharmacy; and

(ii) the review and processing of the prescription by a pharmacist licensed by the state in which the pharmacy is located, who is employed by or under contract to the pharmacy;

(5) prescriptions, policies, procedures, and records of delivery are maintained by the manufacturer for a minimum of three years and are made available to the board upon request; and

(6) the manufacturer or the manufacturer's agent delivers the dialysate or devices directly to:

(i) a patient with end-stage renal disease for whom the prescription was written or the patient's designee, for the patient's self-administration of the dialysis therapy; or

(ii) a health care provider or institution, for administration or delivery of the dialysis therapy to a patient with end-stage renal disease for whom the prescription was written.

Sec. 33. Minnesota Statutes 2018, section 151.19, subdivision 3, is amended to read:

Subd. 3. **Sale of federally restricted medical gases.** (a) A person or establishment not licensed as a pharmacy or a practitioner shall not engage in the retail sale or distribution of federally restricted medical gases without first obtaining a registration from the board and paying the applicable fee specified in section 151.065. The registration shall be displayed in a conspicuous place in the business for which it is issued and expires on the date set by the board. It is unlawful for a person to sell or distribute federally restricted medical gases unless a certificate has been issued to that person by the board.

(b) Application for a medical gas distributor registration under this section shall be made in a manner specified by the board.

(c) No registration shall be issued or renewed for a medical gas distributor located within the state unless the applicant agrees to operate in a manner prescribed by federal and state law and according to the rules adopted by the board. No license shall be issued for a medical gas distributor located outside of the state unless the applicant agrees to operate in a manner prescribed by federal law and, when distributing medical gases for residents of this state, the laws of this state and Minnesota Rules.

(d) No registration shall be issued or renewed for a medical gas distributor that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of the licensure or registration. The board may, by rule,

establish standards for the registration of a medical gas distributor that is not required to be licensed or registered by the state in which it is physically located.

(e) The board shall require a separate registration for each medical gas distributor located within the state and for each facility located outside of the state from which medical gases are distributed to residents of this state.

(f) ~~The board shall not issue~~ Prior to the issuance of an initial or renewed registration for a medical gas distributor ~~unless~~, the board may require the medical gas distributor ~~passes~~ to pass an inspection conducted by an authorized representative of the board. In the case of a medical gas distributor located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

Sec. 34. Minnesota Statutes 2018, section 151.252, subdivision 1, is amended to read:

Subdivision 1. **Requirements.** (a) No person shall act as a drug manufacturer without first obtaining a license from the board and paying any applicable fee specified in section 151.065.

(b) Application for a drug manufacturer license under this section shall be made in a manner specified by the board.

(c) No license shall be issued or renewed for a drug manufacturer unless the applicant agrees to operate in a manner prescribed by federal and state law and according to Minnesota Rules.

(d) No license shall be issued or renewed for a drug manufacturer that is required to be registered pursuant to United States Code, title 21, section 360, unless the applicant supplies the board with proof of registration. The board may establish by rule the standards for licensure of drug manufacturers that are not required to be registered under United States Code, title 21, section 360.

(e) No license shall be issued or renewed for a drug manufacturer that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of licensure or registration. The board may establish, by rule,

standards for the licensure of a drug manufacturer that is not required to be licensed or registered by the state in which it is physically located.

(f) The board shall require a separate license for each facility located within the state at which drug manufacturing occurs and for each facility located outside of the state at which drugs that are shipped into the state are manufactured.

(g) ~~The board shall not issue~~ Prior to the issuance of an initial or renewed license for a drug manufacturing facility ~~unless~~, the board may require the facility ~~passes an~~ to pass a current good manufacturing practices inspection conducted by an authorized representative of the board. In the case of a drug manufacturing facility located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located or by the United States Food and Drug Administration, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

Sec. 35. Minnesota Statutes 2018, section 151.252, subdivision 1a, is amended to read:

Subd. 1a. **Outsourcing facility.** (a) No person shall act as an outsourcing facility without first obtaining a license from the board and paying any applicable manufacturer licensing fee specified in section 151.065.

(b) Application for an outsourcing facility license under this section shall be made in a manner specified by the board and may differ from the application required of other drug manufacturers.

(c) No license shall be issued or renewed for an outsourcing facility unless the applicant agrees to operate in a manner prescribed for outsourcing facilities by federal and state law and according to Minnesota Rules.

(d) No license shall be issued or renewed for an outsourcing facility unless the applicant supplies the board with proof of such registration by the United States Food and Drug Administration as required by United States Code, title 21, section 353b.

(e) No license shall be issued or renewed for an outsourcing facility that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of such licensure or registration. The board may establish, by

rule, standards for the licensure of an outsourcing facility that is not required to be licensed or registered by the state in which it is physically located.

(f) The board shall require a separate license for each outsourcing facility located within the state and for each outsourcing facility located outside of the state at which drugs that are shipped into the state are prepared.

(g) The board shall not issue an initial or renewed license for an outsourcing facility unless the facility passes ~~an~~ a current good manufacturing practices inspection conducted by an authorized representative of the board. In the case of an outsourcing facility located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located or by the United States Food and Drug Administration, of ~~an~~ a current good manufacturing practices inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

Sec. 36. Minnesota Statutes 2018, section 151.252, subdivision 3, is amended to read:

Subd. 3. **Payment to practitioner; reporting.** Unless prohibited by United States Code, title 42, section 1320a-7h, a drug manufacturer or outsourcing facility shall file with the board an annual report, in a form and on the date prescribed by the board, identifying all payments, honoraria, reimbursement, or other compensation authorized under section 151.461, clauses (4) and (5), paid to practitioners in Minnesota during the preceding calendar year. The report shall identify the nature and value of any payments totaling $100 or more to a particular practitioner during the year, and shall identify the practitioner. Reports filed under this subdivision are public data.

Sec. 37. Minnesota Statutes 2018, section 151.253, is amended by adding a subdivision to read:

Subd. 4. **Emergency veterinary compounding.** A pharmacist working within a pharmacy licensed by the board in the veterinary pharmacy license category may compound and provide a drug product to a veterinarian without first receiving a patient-specific prescription only when:

(1) the compounded drug product is needed to treat animals in urgent or emergency situations, meaning where the health of an animal is threatened, or where suffering or death of an animal is likely to result from failure to immediately treat;

(2) timely access to a compounding pharmacy is not available, as determined by the prescribing veterinarian;

(3) there is no commercially manufactured drug, approved by the United States Food and Drug Administration, that is suitable for treating the animal, or there is a documented shortage of such drug;

(4) the compounded drug is to be administered by a veterinarian or a bona fide employee of the veterinarian, or dispensed to a client of a veterinarian in an amount not to exceed what is necessary to treat an animal for a period of ten days;

(5) the pharmacy has selected the sterile or nonsterile compounding license category, in addition to the veterinary pharmacy licensing category; and

(6) the pharmacy is appropriately registered by the United States Drug Enforcement Administration when providing compounded products that contain controlled substances.

Sec. 38. Minnesota Statutes 2018, section 151.32, is amended to read:

**151.32 CITATION.**

The title of sections 151.01 to ~~151.40~~ 151.58 shall be the Pharmacy Practice and Wholesale Distribution Act.

Sec. 39. Minnesota Statutes 2018, section 151.40, subdivision 1, is amended to read:

Subdivision 1. **Generally.** ~~Except as otherwise provided in subdivision 2,~~ It is unlawful for any person to possess, control, manufacture, sell, furnish, dispense, or otherwise dispose of hypodermic syringes or needles or any instrument or implement which can be adapted for subcutaneous injections, except ~~by~~ for:

(1) The following persons when acting in the course of their practice or employment:

(i) licensed practitioners~~, registered~~ and their employees, agents, or delegates;

(ii) licensed pharmacies and their employees or agents~~,~~;

(iii) licensed pharmacists~~, licensed doctors of veterinary medicine or their assistants,~~;

(iv) registered nurses~~,~~ and licensed practical nurses;

(v) registered medical technologists~~,~~;

(vi) medical interns~~,~~ and residents;

(vii) licensed drug wholesalers~~,~~ and their employees or agents~~,~~;

(viii) licensed hospitals~~,~~;

(ix) bona fide hospitals in which animals are treated;

(x) licensed nursing homes~~, bona fide hospitals where animals are treated,~~;

(xi) licensed morticians~~,~~;

(xii) syringe and needle manufacturers~~,~~ and their dealers and agents~~,~~;

(xiii) persons engaged in animal husbandry~~,~~;

(xiv) clinical laboratories and their employees~~,~~;

(xv) persons engaged in bona fide research or education or industrial use of hypodermic syringes and needles provided such persons cannot use hypodermic syringes and needles for the administration of drugs to human beings unless such drugs are prescribed, dispensed, and administered by a person lawfully authorized to do so~~,~~;

(xvi) persons who administer drugs pursuant to an order or direction of a licensed ~~doctor of medicine or of a licensed doctor of osteopathic medicine duly licensed to practice medicine.~~ practitioner; and

(xvii) syringe service providers and their employees or agents and individuals who obtain and dispose of hypodermic syringes and needles through such providers;

(2) a person who self-administers drugs pursuant to either the prescription or the direction of a practitioner, or a family member, caregiver, or other individual who is designated by such person to assist the person in obtaining and using needles and syringes for the administration of such drugs;

(3) a person who is disposing of hypodermic syringes and needles through an activity or program developed under section 325F.785; or

(4) a person who sells, possesses, or handles hypodermic syringes and needles pursuant to subdivision 2.

Sec. 40. Minnesota Statutes 2018, section 151.40, subdivision 2, is amended to read:

Subd. 2. **Sales of limited quantities of clean needles and syringes.** (a) A registered pharmacy ~~or its agent~~ or a licensed pharmacist may sell, without ~~a~~ the prescription or direction of a practitioner, unused hypodermic needles and syringes in quantities of ten or

fewer, provided the pharmacy or pharmacist complies with all of the requirements of this subdivision.

(b) At any location where hypodermic needles and syringes are kept for retail sale under this subdivision, the needles and syringes shall be stored in a manner that makes them available only to authorized personnel and not openly available to customers.

~~(c) No registered pharmacy or licensed pharmacist may advertise to the public the availability for retail sale, without a prescription, of hypodermic needles or syringes in quantities of ten or fewer.~~

~~(d)~~ (c) A registered pharmacy or licensed pharmacist that sells hypodermic needles or syringes under this subdivision may give the purchaser the materials developed by the commissioner of health under section 325F.785.

~~(e)~~ (d) A registered pharmacy or licensed pharmacist that sells hypodermic needles or syringes under this subdivision must certify to the commissioner of health participation in an activity, including but not limited to those developed under section 325F.785, that supports proper disposal of used hypodermic needles or syringes.

Sec. 41. Minnesota Statutes 2018, section 151.43, is amended to read:

**151.43 SCOPE.**

Sections ~~151.42~~ 151.43 to 151.51 apply to any person~~, partnership, corporation, or business firm~~ engaging in the wholesale distribution of ~~prescription~~ drugs within the state, and to persons operating as third-party logistics providers.

Sec. 42. **[151.441] DEFINITIONS.**

Subdivision 1. **Scope.** As used in sections 151.43 to 151.51, the following terms have the meanings given in this section.

Subd. 2. **Dispenser.** "Dispenser" means a retail pharmacy, hospital pharmacy, a group of chain pharmacies under common ownership and control that do not act as a wholesale distributor, or any other person authorized by law to dispense or administer prescription drugs, and the affiliated warehouses or distribution centers of such entities under common ownership and control that do not act as a wholesale distributor, but does not include a person who dispenses only products to be used in animals in accordance with United States Code, title 21, section 360b(a)(5).

Subd. 3. **Disposition.** "Disposition," with respect to a product within the possession or control of an entity, means the removal of such product from the pharmaceutical distribution supply chain, which may include disposal or return of the product for disposal or other appropriate handling and other actions, such as retaining a sample of the product for further additional physical examination or laboratory analysis of the product by a manufacturer or regulatory or law enforcement agency.

Subd. 4. **Distribute or distribution.** "Distribute" or "distribution" means the sale, purchase, trade, delivery, handling, storage, or receipt of a product, and does not include the dispensing of a product pursuant to a prescription executed in accordance with United States Code, title 21, section 353(b)(1), or the dispensing of a product approved under United States Code, title 21, section 360b(b).

Subd. 5. **Manufacturer.** "Manufacturer" means, with respect to a product:

(1) a person who holds an application approved under United States Code, title 21, section 355, or a license issued under United States Code, title 42, section 262, for such product, or if such product is not the subject of an approved application or license, the person who manufactured the product;

(2) a co-licensed partner of the person described in clause (1) that obtains the product directly from a person described in this subdivision; or

(3) an affiliate of a person described in clause (1) or (2) that receives the product directly from a person described in this subdivision.

Subd. 6. **Medical convenience kit.** "Medical convenience kit" means a collection of finished medical devices, which may include a product or biological product, assembled in kit form strictly for the convenience of the purchaser or user.

Subd. 7. **Package.** "Package" means the smallest individual salable unit of product for distribution by a manufacturer or repackager that is intended by the manufacturer for ultimate sale to the dispenser of such product. For purposes of this subdivision, an "individual salable unit" is the smallest container of product introduced into commerce by the manufacturer or repackager that is intended by the manufacturer or repackager for individual sale to a dispenser.

Subd. 8. **Prescription drug.** "Prescription drug" means a drug for human use subject to United States Code, title 21, section 353(b)(1).

Subd. 9. **Product.** "Product" means a prescription drug in a finished dosage form for administration to a patient without substantial further manufacturing, but does not include

blood or blood components intended for transfusion; radioactive drugs or radioactive biological products as defined in Code of Federal Regulations, title 21, section 600.3(ee), that are regulated by the Nuclear Regulatory Commission or by a state pursuant to an agreement with such commission under United States Code, title 42, section 2021; imaging drugs; an intravenous product described in subdivision 12, paragraph (b), clauses (14) to (16); any medical gas defined in United States Code, title 21, section 360ddd; homeopathic drugs marketed in accordance with applicable federal law; or a drug compounded in compliance with United States Code, title 21, section 353a or 353b.

Subd. 10. **Repackager.** "Repackager" means a person who owns or operates an establishment that repacks and relabels a product or package for further sale or for distribution without a further transaction.

Subd. 11. **Third-party logistics provider.** "Third-party logistics provider" means an entity that provides or coordinates warehousing or other logistics services of a product in interstate commerce on behalf of a manufacturer, wholesale distributor, or dispenser of a product, but does not take ownership of the product nor have responsibility to direct the sale or disposition of the product.

Subd. 12. **Transaction.** (a) "Transaction" means the transfer of product between persons in which a change of ownership occurs.

(b) The term "transaction" does not include:

(1) intracompany distribution of any product between members of an affiliate or within a manufacturer;

(2) the distribution of a product among hospitals or other health care entities that are under common control;

(3) the distribution of a drug or an offer to distribute a drug for emergency medical reasons, including:

(i) a public health emergency declaration pursuant to United States Code, title 42, section 247d;

(ii) a national security or peacetime emergency declared by the governor pursuant to section 12.31; or

(iii) a situation involving an action taken by the commissioner of health pursuant to section 144.4197, 144.4198 or 151.37, subdivisions 2, paragraph (b), and 10, except that, for purposes of this paragraph, a drug shortage not caused by a public health emergency shall not constitute an emergency medical reason;

(4) the dispensing of a drug pursuant to a valid prescription issued by a licensed practitioner;

(5) the distribution of product samples by a manufacturer or a licensed wholesale distributor in accordance with United States Code, title 21, section 353(d);

(6) the distribution of blood or blood components intended for transfusion;

(7) the distribution of minimal quantities of product by a licensed retail pharmacy to a licensed practitioner for office use;

(8) the sale, purchase, or trade of a drug or an offer to sell, purchase, or trade a drug by a charitable organization described in United States Code, title 26, section 501(c)(3), to a nonprofit affiliate of the organization to the extent otherwise permitted by law;

(9) the distribution of a product pursuant to the sale or merger of a pharmacy or pharmacies or a wholesale distributor or wholesale distributors, except that any records required to be maintained for the product shall be transferred to the new owner of the pharmacy or pharmacies or wholesale distributor or wholesale distributors;

(10) the dispensing of a product approved under United States Code, title 21, section 360b(c);

(11) transfer of products to or from any facility that is licensed by the Nuclear Regulatory Commission or by a state pursuant to an agreement with such commission under United States Code, title 42, section 2021;

(12) transfer of a combination product that is not subject to approval under United States Code, title 21, section 355, or licensure under United States Code, title 42, section 262, and that is:

(i) a product comprised of a device and one or more other regulated components (such as a drug/device, biologic/device, or drug/device/biologic) that are physically, chemically, or otherwise combined or mixed and produced as a single entity;

(ii) two or more separate products packaged together in a single package or as a unit and comprised of a drug and device or device and biological product; or

(iii) two or more finished medical devices plus one or more drug or biological products that are packaged together in a medical convenience kit;

(13) the distribution of a medical convenience kit if:

(i) the medical convenience kit is assembled in an establishment that is registered with the Food and Drug Administration as a device manufacturer in accordance with United States Code, title 21, section 360(b)(2);

(ii) the medical convenience kit does not contain a controlled substance that appears in a schedule contained in the Comprehensive Drug Abuse Prevention and Control Act of 1970, United States Code, title 21, section 801, et seq.;

(iii) in the case of a medical convenience kit that includes a product, the person who manufactures the kit:

(A) purchased the product directly from the pharmaceutical manufacturer or from a wholesale distributor that purchased the product directly from the pharmaceutical manufacturer; and

(B) does not alter the primary container or label of the product as purchased from the manufacturer or wholesale distributor; and

(iv) in the case of a medical convenience kit that includes a product, the product is:

(A) an intravenous solution intended for the replenishment of fluids and electrolytes;

(B) a product intended to maintain the equilibrium of water and minerals in the body;

(C) a product intended for irrigation or reconstitution;

(D) an anesthetic;

(E) an anticoagulant;

(F) a vasopressor; or

(G) a sympathomimetic;

(14) the distribution of an intravenous product that, by its formulation, is intended for the replenishment of fluids and electrolytes, such as sodium, chloride, and potassium; or calories, such as dextrose and amino acids;

(15) the distribution of an intravenous product used to maintain the equilibrium of water and minerals in the body, such as dialysis solutions;

(16) the distribution of a product that is intended for irrigation, or sterile water, whether intended for such purposes or for injection;

(17) the distribution of a medical gas as defined in United States Code, title 21, section 360ddd; or

(18) the distribution or sale of any licensed product under United States Code, title 42, section 262, that meets the definition of a device under United States Code, title 21, section 321(h).

Subd. 13. **Wholesale distribution.** "Wholesale distribution" means the distribution of a drug to a person other than a consumer or patient, or receipt of a drug by a person other than the consumer or patient, but does not include:

(1) intracompany distribution of any drug between members of an affiliate or within a manufacturer;

(2) the distribution of a drug or an offer to distribute a drug among hospitals or other health care entities that are under common control;

(3) the distribution of a drug or an offer to distribute a drug for emergency medical reasons, including:

(i) a public health emergency declaration pursuant to United States Code, title 42, section 247d;

(ii) a national security or peacetime emergency declared by the governor pursuant to section 12.31; or

(iii) a situation involving an action taken by the commissioner of health pursuant to sections 144.4197, 144.4198 or 151.37, subdivisions 2, paragraph (b), and 10, except that, for purposes of this paragraph, a drug shortage not caused by a public health emergency shall not constitute an emergency medical reason;

(4) the dispensing of a drug pursuant to a valid prescription issued by a licensed practitioner;

(5) the distribution of minimal quantities of a drug by a licensed retail pharmacy to a licensed practitioner for office use;

(6) the distribution of a drug or an offer to distribute a drug by a charitable organization to a nonprofit affiliate of the organization to the extent otherwise permitted by law;

(7) the purchase or other acquisition by a dispenser, hospital, or other health care entity of a drug for use by such dispenser, hospital, or other health care entity;

(8) the distribution of a drug by the manufacturer of such drug;

(9) the receipt or transfer of a drug by an authorized third-party logistics provider provided that such third-party logistics provider does not take ownership of the drug;

(10) a common carrier that transports a drug, provided that the common carrier does not take ownership of the drug;

(11) the distribution of a drug or an offer to distribute a drug by an authorized repackager that has taken ownership or possession of the drug and repacks it in accordance with United States Code, title 21, section 360eee-1(e);

(12) salable drug returns when conducted by a dispenser;

(13) the distribution of a collection of finished medical devices, which may include a product or biological product, assembled in kit form strictly for the convenience of the purchaser or user, referred to in this section as a medical convenience kit, if:

(i) the medical convenience kit is assembled in an establishment that is registered with the Food and Drug Administration as a device manufacturer in accordance with United States Code, title 21, section 360(b)(2);

(ii) the medical convenience kit does not contain a controlled substance that appears in a schedule contained in the Comprehensive Drug Abuse Prevention and Control Act of 1970, United States Code, title 21, section 801, et seq.;

(iii) in the case of a medical convenience kit that includes a product, the person that manufactures the kit:

(A) purchased such product directly from the pharmaceutical manufacturer or from a wholesale distributor that purchased the product directly from the pharmaceutical manufacturer; and

(B) does not alter the primary container or label of the product as purchased from the manufacturer or wholesale distributor; and

(iv) in the case of a medical convenience kit that includes a product, the product is:

(A) an intravenous solution intended for the replenishment of fluids and electrolytes;

(B) a product intended to maintain the equilibrium of water and minerals in the body;

(C) a product intended for irrigation or reconstitution;

(D) an anesthetic;

(E) an anticoagulant;

(F) a vasopressor; or

(G) a sympathomimetic;

(14) the distribution of an intravenous drug that, by its formulation, is intended for the replenishment of fluids and electrolytes, such as sodium, chloride, and potassium; or calories, such as dextrose and amino acids;

(15) the distribution of an intravenous drug used to maintain the equilibrium of water and minerals in the body, such as dialysis solutions;

(16) the distribution of a drug that is intended for irrigation, or sterile water, whether intended for such purposes or for injection;

(17) the distribution of medical gas, as defined in United States Code, title 21, section 360ddd;

(18) facilitating the distribution of a product by providing solely administrative services, including processing of orders and payments; or

(19) the transfer of a product by a hospital or other health care entity, or by a wholesale distributor or manufacturer operating at the direction of the hospital or other health care entity, to a repackager described in United States Code, title 21, section 360eee(16)(B), and registered under United States Code, title 21, section 360, for the purpose of repackaging the drug for use by that hospital, or other health care entity and other health care entities that are under common control, if ownership of the drug remains with the hospital or other health care entity at all times.

Subd. 14. **Wholesale distributor.** "Wholesale distributor" means a person engaged in wholesale distribution but does not include a manufacturer, a manufacturer's co-licensed partner, a third-party logistics provider, or a repackager.

Sec. 43. Minnesota Statutes 2018, section 151.46, is amended to read:

**151.46 PROHIBITED DRUG PURCHASES OR RECEIPT.**

It is unlawful for any person to knowingly purchase or receive a prescription drug from a source other than a person or entity licensed under the laws of the state, except where otherwise provided. Licensed wholesale drug distributors ~~other than pharmacies~~ and licensed third-party logistics providers shall not dispense or distribute ~~prescription~~ drugs directly to patients. A person violating the provisions of this section is guilty of a misdemeanor.

Sec. 44. Minnesota Statutes 2018, section 151.47, subdivision 1, is amended to read:

Subdivision 1. ~~**Requirements**~~ **Generally.** ~~(a) All wholesale drug distributors are subject to the requirements of this subdivision.~~ Each manufacturer, repackager, wholesale distributor,

and dispenser shall comply with the requirements set forth in United States Code, title 21, section 360eee-1, with respect to the role of such manufacturer, repackager, wholesale distributor, or dispenser in a transaction involving a product. If an entity meets the definition of more than one of the entities listed in the preceding sentence, such entity shall comply with all applicable requirements in United States Code, title 21, section 360eee-1, but shall not be required to duplicate requirements.

~~(b) No person or distribution outlet shall act as a wholesale drug distributor without first obtaining a license from the board and paying any applicable fee specified in section 151.065.~~

~~(c) Application for a wholesale drug distributor license under this section shall be made in a manner specified by the board.~~

~~(d) No license shall be issued or renewed for a wholesale drug distributor to operate unless the applicant agrees to operate in a manner prescribed by federal and state law and according to the rules adopted by the board.~~

~~(e) No license may be issued or renewed for a drug wholesale distributor that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of licensure or registration. The board may establish, by rule, standards for the licensure of a drug wholesale distributor that is not required to be licensed or registered by the state in which it is physically located.~~

~~(f) The board shall require a separate license for each drug wholesale distributor facility located within the state and for each drug wholesale distributor facility located outside of the state from which drugs are shipped into the state or to which drugs are reverse distributed.~~

~~(g) The board shall not issue an initial or renewed license for a drug wholesale distributor facility unless the facility passes an inspection conducted by an authorized representative of the board, or is accredited by an accreditation program approved by the board. In the case of a drug wholesale distributor facility located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board, or furnishes the board with proof of current accreditation. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.~~

~~(h) As a condition for receiving and retaining a wholesale drug distributor license issued under sections 151.42 to 151.51, an applicant shall satisfy the board that it has and will continuously maintain:~~

~~(1) adequate storage conditions and facilities;~~

~~(2) minimum liability and other insurance as may be required under any applicable federal or state law;~~

~~(3) a viable security system that includes an after hours central alarm, or comparable entry detection capability; restricted access to the premises; comprehensive employment applicant screening; and safeguards against all forms of employee theft;~~

~~(4) a system of records describing all wholesale drug distributor activities set forth in section 151.44 for at least the most recent two-year period, which shall be reasonably accessible as defined by board regulations in any inspection authorized by the board;~~

~~(5) principals and persons, including officers, directors, primary shareholders, and key management executives, who must at all times demonstrate and maintain their capability of conducting business in conformity with sound financial practices as well as state and federal law;~~

~~(6) complete, updated information, to be provided to the board as a condition for obtaining and retaining a license, about each wholesale drug distributor to be licensed, including all pertinent corporate licensee information, if applicable, or other ownership, principal, key personnel, and facilities information found to be necessary by the board;~~

~~(7) written policies and procedures that assure reasonable wholesale drug distributor preparation for, protection against, and handling of any facility security or operation problems, including, but not limited to, those caused by natural disaster or government emergency, inventory inaccuracies or product shipping and receiving, outdated product or other unauthorized product control, appropriate disposition of returned goods, and product recalls;~~

~~(8) sufficient inspection procedures for all incoming and outgoing product shipments; and~~

~~(9) operations in compliance with all federal requirements applicable to wholesale drug distribution.~~

~~(i) An agent or employee of any licensed wholesale drug distributor need not seek licensure under this section.~~

Sec. 45. Minnesota Statutes 2018, section 151.47, is amended by adding a subdivision to read:

Subd. 1a. **Licensing.** (a) The board shall license wholesale distributors in a manner that is consistent with United States Code, title 21, section 360eee-2, and the regulations promulgated thereunder. In the event that the provisions of this section, or of the rules of the board, conflict with the provisions of United States Code, title 21, section 360eee-2, or the rules promulgated thereunder, the federal provisions shall prevail. The board shall not license a person as a wholesale distributor unless the person is engaged in wholesale distribution.

(b) No person shall act as a wholesale distributor without first obtaining a license from the board and paying any applicable fee specified in section 151.065.

(c) Application for a wholesale distributor license under this section shall be made in a manner specified by the board.

(d) No license shall be issued or renewed for a wholesale distributor unless the applicant agrees to operate in a manner prescribed by federal and state law and according to the rules adopted by the board.

(e) No license may be issued or renewed for a wholesale distributor facility that is located in another state unless the applicant supplies the board with proof of licensure or registration by the state in which the wholesale distributor is physically located or by the United States Food and Drug Administration.

(f) The board shall require a separate license for each drug wholesale distributor facility located within the state and for each drug wholesale distributor facility located outside of the state from which drugs are shipped into the state or to which drugs are reverse distributed.

(g) The board shall not issue an initial or renewed license for a drug wholesale distributor facility unless the facility passes an inspection conducted by an authorized representative of the board or is inspected and accredited by an accreditation program approved by the board. In the case of a drug wholesale distributor facility located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board, or furnishes the board with proof of current accreditation. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

(h) As a condition for receiving and retaining a wholesale drug distributor license issued under this section, an applicant shall satisfy the board that it:

(1) has adequate storage conditions and facilities to allow for the safe receipt, storage, handling, and sale of drugs;

(2) has minimum liability and other insurance as may be required under any applicable federal or state law;

(3) has a functioning security system that includes an after-hours central alarm or comparable entry detection capability, and security policies and procedures that include provisions for restricted access to the premises, comprehensive employee applicant screening, and safeguards against all forms of employee theft;

(4) will maintain appropriate records of the distribution of drugs, which shall be kept for a minimum of two years and be made available to the board upon request;

(5) employs principals and other persons, including officers, directors, primary shareholders, and key management executives, who will at all times demonstrate and maintain their capability of conducting business in conformity with state and federal law, at least one of whom will serve as the primary designated representative for each licensed facility and who will be responsible for ensuring that the facility operates in a manner consistent with state and federal law;

(6) will ensure that all personnel have sufficient education, training, and experience, in any combination, so that they may perform assigned duties in a manner that maintains the quality, safety, and security of drugs;

(7) will provide the board with updated information about each wholesale distributor facility to be licensed, as requested by the board;

(8) will develop and, as necessary, update written policies and procedures that assure reasonable wholesale drug distributor preparation for, protection against, and handling of any facility security or operation problems, including but not limited to those caused by natural disaster or government emergency, inventory inaccuracies or drug shipping and receiving, outdated drugs, appropriate handling of returned goods, and drug recalls;

(9) will have sufficient policies and procedures in place for the inspection of all incoming and outgoing drug shipments;

(10) will operate in compliance with all state and federal requirements applicable to wholesale drug distribution; and

(11) will meet the requirements for inspections found in this subdivision.

(i) An agent or employee of any licensed wholesale drug distributor need not seek licensure under this section. Paragraphs (i) to (p) apply to wholesaler personnel.

(j) The board is authorized to and shall require fingerprint-based criminal background checks of facility managers or designated representatives, as required under United States Code, title 21, section 360eee-2. The criminal background checks shall be conducted as provided in section 214.075. The board shall use the criminal background check data received to evaluate the qualifications of persons for ownership of or employment by a licensed wholesaler and shall not disseminate this data except as allowed by law.

(k) A licensed wholesaler shall not be owned by, or employ, a person who has:

(1) been convicted of any felony for conduct relating to wholesale distribution, any felony violation of United States Code, title 21, section 331, subsections (i) or (k), or any felony violation of United States Code, title 18, section 1365, relating to product tampering; or

(2) engaged in a pattern of violating the requirements of United States Code, title 21, section 360eee-2, or the regulations promulgated thereunder, or state requirements for licensure, that presents a threat of serious adverse health consequences or death to humans.

(l) An applicant for the issuance or renewal of a wholesale distributor license shall execute and file with the board a surety bond.

(m) Prior to issuing or renewing a wholesale distributor license, the board shall require an applicant that is not a government owned and operated wholesale distributor to submit a surety bond of $100,000, except that if the annual gross receipts of the applicant for the previous tax year is $10,000,000 or less, a surety bond of $25,000 shall be required.

(n) If a wholesale distributor can provide evidence satisfactory to the board that it possesses the required bond in another state, the requirement for a bond shall be waived.

(o) The purpose of the surety bond required under this subdivision is to secure payment of any civil penalty imposed by the board pursuant to section 151.071, subdivision 1. The board may make a claim against the bond if the licensee fails to pay a civil penalty within 30 days after the order imposing the fine or costs become final.

(p) A single surety bond shall satisfy the requirement for the submission of a bond for all licensed wholesale distributor facilities under common ownership.

Sec. 46. **[151.471] THIRD-PARTY LOGISTICS PROVIDER REQUIREMENTS.**

Subdivision 1. **Generally.** Each third-party logistics provider shall comply with the requirements set forth in United States Code, title 21, section 360eee to 360eee-4, that are applicable to third-party logistics providers.

Subd. 2. **Licensing.** (a) The board shall license third-party logistics providers in a manner that is consistent with United States Code, title 21, section 360eee-3, and the regulations promulgated thereunder. In the event that the provisions of this section or of the rules of the board conflict with the provisions of United States Code, title 21, section 360eee-3, or the rules promulgated thereunder, the federal provisions shall prevail. The board shall not license a person as a third-party logistics provider unless the person is operating as such.

(b) No person shall act as a third-party logistics provider without first obtaining a license from the board and paying any applicable fee specified in section 151.065.

(c) Application for a third-party logistics provider license under this section shall be made in a manner specified by the board.

(d) No license shall be issued or renewed for a third-party logistics provider unless the applicant agrees to operate in a manner prescribed by federal and state law and according to the rules adopted by the board.

(e) No license may be issued or renewed for a third-party logistics provider facility that is located in another state unless the applicant supplies the board with proof of licensure or registration by the state in which the third-party logistics provider facility is physically located or by the United States Food and Drug Administration.

(f) The board shall require a separate license for each third-party logistics provider facility located within the state and for each third-party logistics provider facility located outside of the state from which drugs are shipped into the state or to which drugs are reverse distributed.

(g) The board shall not issue an initial or renewed license for a third-party logistics provider facility unless the facility passes an inspection conducted by an authorized representative of the board or is inspected and accredited by an accreditation program approved by the board. In the case of a third-party logistics provider facility located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located, of an inspection that has occurred within the 24 months immediately preceding receipt of the

license application by the board, or furnishes the board with proof of current accreditation. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

(h) As a condition for receiving and retaining a third-party logistics provider facility license issued under this section, an applicant shall satisfy the board that it:

(1) has adequate storage conditions and facilities to allow for the safe receipt, storage, handling, and transfer of drugs;

(2) has minimum liability and other insurance as may be required under any applicable federal or state law;

(3) has a functioning security system that includes an after-hours central alarm or comparable entry detection capability, and security policies and procedures that include provisions for restricted access to the premises, comprehensive employee applicant screening, and safeguards against all forms of employee theft;

(4) will maintain appropriate records of the handling of drugs, which shall be kept for a minimum of two years and be made available to the board upon request;

(5) employs principals and other persons, including officers, directors, primary shareholders, and key management executives, who will at all times demonstrate and maintain their capability of conducting business in conformity with state and federal law, at least one of whom will serve as the primary designated representative for each licensed facility and who will be responsible for ensuring that the facility operates in a manner consistent with state and federal law;

(6) will ensure that all personnel have sufficient education, training, and experience, in any combination, so that they may perform assigned duties in a manner that maintains the quality, safety, and security of drugs;

(7) will provide the board with updated information about each third-party logistics provider facility to be licensed by the board;

(8) will develop and, as necessary, update written policies and procedures that ensure reasonable preparation for, protection against, and handling of any facility security or operation problems, including, but not limited to, those caused by natural disaster or government emergency, inventory inaccuracies or drug shipping and receiving, outdated drug, appropriate handling of returned goods, and drug recalls;

(9) will have sufficient policies and procedures in place for the inspection of all incoming and outgoing drug shipments;

(10) will operate in compliance with all state and federal requirements applicable to third-party logistics providers; and

(11) will meet the requirements for inspections found in this subdivision.

(i) An agent or employee of any licensed third-party logistics provider need not seek licensure under this section. Paragraphs (j) and (k) apply to third-party logistics provider personnel.

(j) The board is authorized to and shall require fingerprint-based criminal background checks of facility managers or designated representatives. The criminal background checks shall be conducted as provided in section 214.075. The board shall use the criminal background check data received to evaluate the qualifications of persons for ownership of or employment by a licensed third-party logistics provider and shall not disseminate this data except as allowed by law.

(k) A licensed third-party logistics provider shall not have as a facility manager or designated representative any person who has been convicted of any felony for conduct relating to wholesale distribution, any felony violation of United States Code, title 21, section 331, subsection (i) or (k), or any felony violation of United States Code, title 18, section 1365, relating to product tampering.

Sec. 47. Minnesota Statutes 2018, section 152.126, subdivision 6, is amended to read:

Subd. 6. **Access to reporting system data.** (a) Except as indicated in this subdivision, the data submitted to the board under subdivision 4 is private data on individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.

(b) Except as specified in subdivision 5, the following persons shall be considered permissible users and may access the data submitted under subdivision 4 in the same or similar manner, and for the same or similar purposes, as those persons who are authorized to access similar private data on individuals under federal and state law:

(1) a prescriber or an agent or employee of the prescriber to whom the prescriber has delegated the task of accessing the data, to the extent the information relates specifically to a current patient, to whom the prescriber is:

(i) prescribing or considering prescribing any controlled substance;

(ii) providing emergency medical treatment for which access to the data may be necessary;

(iii) providing care, and the prescriber has reason to believe, based on clinically valid indications, that the patient is potentially abusing a controlled substance; or

(iv) providing other medical treatment for which access to the data may be necessary for a clinically valid purpose and the patient has consented to access to the submitted data, and with the provision that the prescriber remains responsible for the use or misuse of data accessed by a delegated agent or employee;

(2) a dispenser or an agent or employee of the dispenser to whom the dispenser has delegated the task of accessing the data, to the extent the information relates specifically to a current patient to whom that dispenser is dispensing or considering dispensing any controlled substance and with the provision that the dispenser remains responsible for the use or misuse of data accessed by a delegated agent or employee;

(3) a licensed pharmacist who is providing pharmaceutical care for which access to the data may be necessary to the extent that the information relates specifically to a current patient for whom the pharmacist is providing pharmaceutical care: (i) if the patient has consented to access to the submitted data; or (ii) if the pharmacist is consulted by a prescriber who is requesting data in accordance with clause (1);

(4) an individual who is the recipient of a controlled substance prescription for which data was submitted under subdivision 4, or a guardian of the individual, parent or guardian of a minor, or health care agent of the individual acting under a health care directive under chapter 145C;

(5) personnel or designees of a health-related licensing board listed in section 214.01, subdivision 2, or of the Emergency Medical Services Regulatory Board, assigned to conduct a bona fide investigation of a complaint received by that board that alleges that a specific licensee is impaired by use of a drug for which data is collected under subdivision 4, has engaged in activity that would constitute a crime as defined in section 152.025, or has engaged in the behavior specified in subdivision 5, paragraph (a);

(6) personnel of the board engaged in the collection, review, and analysis of controlled substance prescription information as part of the assigned duties and responsibilities under this section;

(7) authorized personnel of a vendor under contract with the state of Minnesota who are engaged in the design, implementation, operation, and maintenance of the prescription monitoring program as part of the assigned duties and responsibilities of their employment, provided that access to data is limited to the minimum amount necessary to carry out such duties and responsibilities, and subject to the requirement of de-identification and time limit on retention of data specified in subdivision 5, paragraphs (d) and (e);

(8) federal, state, and local law enforcement authorities acting pursuant to a valid search warrant;

(9) personnel of the Minnesota health care programs assigned to use the data collected under this section to identify and manage recipients whose usage of controlled substances may warrant restriction to a single primary care provider, a single outpatient pharmacy, and a single hospital;

(10) personnel of the Department of Human Services assigned to access the data pursuant to paragraph (i);

(11) personnel of the health professionals services program established under section 214.31, to the extent that the information relates specifically to an individual who is currently enrolled in and being monitored by the program, and the individual consents to access to that information. The health professionals services program personnel shall not provide this data to a health-related licensing board or the Emergency Medical Services Regulatory Board, except as permitted under section 214.33, subdivision 3.

For purposes of clause (4), access by an individual includes persons in the definition of an individual under section 13.02; and

(12) personnel or designees of a health-related licensing board listed in section 214.01, subdivision 2, assigned to conduct a bona fide investigation of a complaint received by that board that alleges that a specific licensee is inappropriately prescribing controlled substances as defined in this section.

(c) By July 1, 2017, every prescriber licensed by a health-related licensing board listed in section 214.01, subdivision 2, practicing within this state who is authorized to prescribe controlled substances for humans and who holds a current registration issued by the federal Drug Enforcement Administration, and every pharmacist licensed by the board and practicing within the state, shall register and maintain a user account with the prescription monitoring program. Data submitted by a prescriber, pharmacist, or their delegate during the registration application process, other than their name, license number, and license type, is classified as private pursuant to section 13.02, subdivision 12.

(d) Only permissible users identified in paragraph (b), clauses (1), (2), (3), (6), (7), (9), and (10), may directly access the data electronically. No other permissible users may directly access the data electronically. If the data is directly accessed electronically, the permissible user shall implement and maintain a comprehensive information security program that contains administrative, technical, and physical safeguards that are appropriate to the user's size and complexity, and the sensitivity of the personal information obtained. The permissible

user shall identify reasonably foreseeable internal and external risks to the security, confidentiality, and integrity of personal information that could result in the unauthorized disclosure, misuse, or other compromise of the information and assess the sufficiency of any safeguards in place to control the risks.

(e) The board shall not release data submitted under subdivision 4 unless it is provided with evidence, satisfactory to the board, that the person requesting the information is entitled to receive the data.

(f) The board shall maintain a log of all persons who access the data for a period of at least three years and shall ensure that any permissible user complies with paragraph ~~(c)~~ (d) prior to attaining direct access to the data.

(g) Section 13.05, subdivision 6, shall apply to any contract the board enters into pursuant to subdivision 2. A vendor shall not use data collected under this section for any purpose not specified in this section.

(h) The board may participate in an interstate prescription monitoring program data exchange system provided that permissible users in other states have access to the data only as allowed under this section, and that section 13.05, subdivision 6, applies to any contract or memorandum of understanding that the board enters into under this paragraph.

(i) With available appropriations, the commissioner of human services shall establish and implement a system through which the Department of Human Services shall routinely access the data for the purpose of determining whether any client enrolled in an opioid treatment program licensed according to chapter 245A has been prescribed or dispensed a controlled substance in addition to that administered or dispensed by the opioid treatment program. When the commissioner determines there have been multiple prescribers or multiple prescriptions of controlled substances, the commissioner shall:

(1) inform the medical director of the opioid treatment program only that the commissioner determined the existence of multiple prescribers or multiple prescriptions of controlled substances; and

(2) direct the medical director of the opioid treatment program to access the data directly, review the effect of the multiple prescribers or multiple prescriptions, and document the review.

If determined necessary, the commissioner of human services shall seek a federal waiver of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section 2.34, paragraph (c), prior to implementing this paragraph.

(j) The board shall review the data submitted under subdivision 4 on at least a quarterly basis and shall establish criteria, in consultation with the advisory task force, for referring information about a patient to prescribers and dispensers who prescribed or dispensed the prescriptions in question if the criteria are met.

(k) The board shall conduct random audits, on at least a quarterly basis, of electronic access by permissible users, as identified in paragraph (b), clauses (1), (2), (3), (6), (7), (9), and (10), to the data in subdivision 4, to ensure compliance with permissible use as defined in this section. A permissible user whose account has been selected for a random audit shall respond to an inquiry by the board, no later than 30 days after receipt of notice that an audit is being conducted. Failure to respond may result in deactivation of access to the electronic system and referral to the appropriate health licensing board, or the commissioner of human services, for further action.

(l) A permissible user who has delegated the task of accessing the data in subdivision 4 to an agent or employee shall audit the use of the electronic system by delegated agents or employees on at least a quarterly basis to ensure compliance with permissible use as defined in this section. When a delegated agent or employee has been identified as inappropriately accessing data, the permissible user must immediately remove access for that individual and notify the board within seven days. The board shall notify all permissible users associated with the delegated agent or employee of the alleged violation.

Sec. 48. **REPEALER.**

(a) Minnesota Statutes 2018, sections 151.42; 151.44; 151.49; 151.50; 151.51; and 151.55, are repealed.

(b) Minnesota Rules, parts 6400.6970; 7200.6100; and 7200.6105, are repealed.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

## ARTICLE 12
## HEALTH DEPARTMENT

Section 1. Minnesota Statutes 2018, section 16A.151, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** (a) If a state official litigates or settles a matter on behalf of specific injured persons or entities, this section does not prohibit distribution of money to the specific injured persons or entities on whose behalf the litigation or settlement efforts were initiated. If money recovered on behalf of injured persons or entities cannot reasonably be distributed to those persons or entities because they cannot readily be located or identified or because

the cost of distributing the money would outweigh the benefit to the persons or entities, the money must be paid into the general fund.

(b) Money recovered on behalf of a fund in the state treasury other than the general fund may be deposited in that fund.

(c) This section does not prohibit a state official from distributing money to a person or entity other than the state in litigation or potential litigation in which the state is a defendant or potential defendant.

(d) State agencies may accept funds as directed by a federal court for any restitution or monetary penalty under United States Code, title 18, section 3663(a)(3) or United States Code, title 18, section 3663A(a)(3). Funds received must be deposited in a special revenue account and are appropriated to the commissioner of the agency for the purpose as directed by the federal court.

(e) Tobacco settlement revenues as defined in section 16A.98, subdivision 1, paragraph (t), may be deposited as provided in section 16A.98, subdivision 12.

(f) Money recovered by or ordered to be paid to the state from one or more tobacco product manufacturers, including future annual payments and arrears payments, under the terms of a settlement or judgment from litigation regarding annual tobacco settlement payments on transferred tobacco brands, shall be deposited in the tobacco use prevention account under section 144.398. For purposes of this paragraph, "litigation regarding annual tobacco settlement payments on transferred tobacco brands" has the meaning given in section 144.398, subdivision 3, paragraph (c).

**EFFECTIVE DATE.** Paragraph (f) is effective the day following final enactment and applies to settlements reached or judgments entered on or after that date.

Sec. 2. Minnesota Statutes 2018, section 18K.02, subdivision 3, is amended to read:

Subd. 3. **Industrial hemp.** "Industrial hemp" means the plant Cannabis sativa L. and any part of the plant, whether growing or not, including the plant's seeds, and all the plant's derivatives, extracts, cannabinoids, isomers, acids, salts, and salts of isomers, whether growing or not, with a delta-9 tetrahydrocannabinol concentration of not more than 0.3 percent on a dry weight basis. Industrial hemp is not marijuana as defined in section 152.01, subdivision 9.

Sec. 3. Minnesota Statutes 2018, section 18K.03, is amended to read:

**18K.03 AGRICULTURAL CROP; POSSESSION AUTHORIZED.**

Subdivision 1. **Industrial hemp.** Industrial hemp is an agricultural crop in this state. A person may possess, transport, process, sell, or buy industrial hemp that is grown pursuant to this chapter.

Subd. 2. **Sale to medical cannabis manufacturers.** A licensee under this chapter may sell hemp to a medical cannabis manufacturer as authorized under sections 152.22 to 152.37.

Sec. 4. Minnesota Statutes 2018, section 103I.005, subdivision 2, is amended to read:

Subd. 2. **Boring.** "Boring" means a hole or excavation that ~~is not used to extract water and~~ includes exploratory borings, bored geothermal heat exchangers, temporary borings, and elevator borings.

Sec. 5. Minnesota Statutes 2018, section 103I.005, subdivision 8a, is amended to read:

Subd. 8a. **Environmental well.** "Environmental well" means an excavation 15 or more feet in depth that is drilled, cored, bored, washed, driven, dug, jetted, or otherwise constructed to:

(1) conduct physical, chemical, or biological testing of groundwater, and includes a groundwater quality monitoring or sampling well;

(2) lower a groundwater level to control or remove contamination in groundwater, and includes a remedial well and excludes horizontal trenches; or

(3) monitor or measure physical, chemical, radiological, or biological parameters of the earth and earth fluids, or for vapor recovery or venting systems. An environmental well includes an excavation used to:

(i) measure groundwater levels, including a piezometer;

(ii) determine groundwater flow direction or velocity;

(iii) measure earth properties such as hydraulic conductivity, bearing capacity, or resistance;

(iv) obtain samples of geologic materials for testing or classification; or

(v) remove or remediate pollution or contamination from groundwater or soil through the use of a vent, vapor recovery system, or sparge point.

An environmental well does not include an exploratory boring.

Sec. 6. Minnesota Statutes 2018, section 103I.005, subdivision 17a, is amended to read:

Subd. 17a. **Temporary ~~environmental well~~ boring.** ~~"Temporary environmental well" means an environmental well as defined in section 103I.005, subdivision 8a, that is sealed within 72 hours of the time construction on the well begins.~~ "Temporary boring" means an excavation that is 15 feet or more in depth, is sealed within 72 hours of the time of construction, and is drilled, cored, washed, driven, dug, jetted, or otherwise constructed to:

(1) conduct physical, chemical, or biological testing of groundwater, including groundwater quality monitoring;

(2) monitor or measure physical, chemical, radiological, or biological parameters of earth materials or earth fluids, including hydraulic conductivity, bearing capacity, or resistance;

(3) measure groundwater levels, including use of a piezometer; and

(4) determine groundwater flow direction or velocity.

Sec. 7. Minnesota Statutes 2018, section 103I.205, subdivision 1, is amended to read:

Subdivision 1. **Notification required.** (a) Except as provided in paragraph (d), a person may not construct a water-supply, dewatering, or environmental well until a notification of the proposed well on a form prescribed by the commissioner is filed with the commissioner with the filing fee in section 103I.208, and, when applicable, the person has met the requirements of paragraph (e). If after filing the well notification an attempt to construct a well is unsuccessful, a new notification is not required unless the information relating to the successful well has substantially changed. A notification is not required prior to construction of a temporary ~~environmental well~~ boring.

(b) The property owner, the property owner's agent, or the licensed contractor where a well is to be located must file the well notification with the commissioner.

(c) The well notification under this subdivision preempts local permits and notifications, and counties or home rule charter or statutory cities may not require a permit or notification for wells unless the commissioner has delegated the permitting or notification authority under section 103I.111.

(d) A person who is an individual that constructs a drive point water-supply well on property owned or leased by the individual for farming or agricultural purposes or as the individual's place of abode must notify the commissioner of the installation and location of the well. The person must complete the notification form prescribed by the commissioner

and mail it to the commissioner by ten days after the well is completed. A fee may not be charged for the notification. A person who sells drive point wells at retail must provide buyers with notification forms and informational materials including requirements regarding wells, their location, construction, and disclosure. The commissioner must provide the notification forms and informational materials to the sellers.

(e) When the operation of a well will require an appropriation permit from the commissioner of natural resources, a person may not begin construction of the well until the person submits the following information to the commissioner of natural resources:

(1) the location of the well;

(2) the formation or aquifer that will serve as the water source;

(3) the maximum daily, seasonal, and annual pumpage rates and volumes that will be requested in the appropriation permit; and

(4) other information requested by the commissioner of natural resources that is necessary to conduct the preliminary assessment required under section 103G.287, subdivision 1, paragraph (c).

The person may begin construction after receiving preliminary approval from the commissioner of natural resources.

Sec. 8. Minnesota Statutes 2018, section 103I.205, subdivision 4, is amended to read:

Subd. 4. **License required.** (a) Except as provided in paragraph (b), (c), (d), or (e), section 103I.401, subdivision 2, or 103I.601, subdivision 2, a person may not drill, construct, repair, or seal a well or boring unless the person has a well contractor's license in possession.

(b) A person may construct, repair, and seal an environmental well or temporary boring if the person:

(1) is a professional engineer licensed under sections 326.02 to 326.15 in the branches of civil or geological engineering;

(2) is a hydrologist or hydrogeologist certified by the American Institute of Hydrology;

(3) is a professional geoscientist licensed under sections 326.02 to 326.15;

(4) is a geologist certified by the American Institute of Professional Geologists; or

(5) meets the qualifications established by the commissioner in rule.

A person must be licensed by the commissioner as an environmental well contractor on forms provided by the commissioner.

(c) A person may do the following work with a limited well/boring contractor's license in possession. A separate license is required for each of the four activities:

(1) installing, repairing, and modifying well screens, pitless units and pitless adaptors, well pumps and pumping equipment, and well casings from the pitless adaptor or pitless unit to the upper termination of the well casing;

(2) sealing wells and borings;

(3) constructing, repairing, and sealing dewatering wells; or

(4) constructing, repairing, and sealing bored geothermal heat exchangers.

(d) A person may construct, repair, and seal an elevator boring with an elevator boring contractor's license.

(e) Notwithstanding other provisions of this chapter requiring a license, a license is not required for a person who complies with the other provisions of this chapter if the person is:

(1) an individual who constructs a water-supply well on land that is owned or leased by the individual and is used by the individual for farming or agricultural purposes or as the individual's place of abode; or

(2) an individual who performs labor or services for a contractor licensed under the provisions of this chapter in connection with the construction, sealing, or repair of a well or boring at the direction and under the personal supervision of a contractor licensed under the provisions of this chapter~~; or~~.

~~(3) a licensed plumber who is repairing submersible pumps or water pipes associated with well water systems if: (i) the repair location is within an area where there is no licensed well contractor within 50 miles, and (ii) the licensed plumber complies with all relevant sections of the plumbing code.~~

Sec. 9. Minnesota Statutes 2018, section 103I.205, subdivision 9, is amended to read:

Subd. 9. **Report of work.** Within ~~30~~ 60 days after completion or sealing of a well or boring, the person doing the work must submit a verified report to the commissioner containing the information specified by rules adopted under this chapter.

Within 30 days after receiving the report, the commissioner shall send or otherwise provide access to a copy of the report to the commissioner of natural resources, to the local soil and water conservation district where the well is located, and to the director of the Minnesota Geological Survey.

Sec. 10. Minnesota Statutes 2018, section 103I.208, subdivision 1, is amended to read:

Subdivision 1. **Well notification fee.** The well notification fee to be paid by a property owner is:

(1) for construction of a water supply well, $275, which includes the state core function fee;

(2) for a well sealing, $75 for each well or temporary boring, which includes the state core function fee, except that: (i) a single notification and fee of $75 is required for all temporary ~~environmental wells recorded on the sealing notification for~~ borings on a single property~~, having depths within a 25 foot range,~~ and sealed within 72 hours of start of construction; and (ii) temporary borings less than 25 feet in depth are exempt from the notification and fee requirements in this chapter;

(3) for construction of a dewatering well, $275, which includes the state core function fee, for each dewatering well except a dewatering project comprising five or more dewatering wells shall be assessed a single fee of $1,375 for the dewatering wells recorded on the notification; and

(4) for construction of an environmental well, $275, which includes the state core function fee, except that a single fee of $275 is required for all environmental wells recorded on the notification that are located on a single property, and except that no fee is required for construction of a temporary ~~environmental well~~ boring.

Sec. 11. Minnesota Statutes 2018, section 103I.235, subdivision 3, is amended to read:

Subd. 3. **Temporary ~~environmental well~~ boring and unsuccessful well exemption.** This section does not apply to temporary ~~environmental wells~~ borings or unsuccessful wells that have been sealed by a licensed contractor in compliance with this chapter.

Sec. 12. Minnesota Statutes 2018, section 103I.301, is amended by adding a subdivision to read:

Subd. 3a. **Temporary boring.** (a) The owner of the property where a temporary boring is located must have the temporary boring sealed within 72 hours after the start of construction of the temporary boring.

(b) The owner must have a well contractor, a limited well/boring sealing contractor, or an environmental well contractor seal the temporary boring.

Sec. 13. Minnesota Statutes 2018, section 103I.301, subdivision 6, is amended to read:

Subd. 6. **Notification required.** A person may not seal a well or temporary boring until a notification of the proposed sealing is filed as prescribed by the commissioner. A single notification is required for all temporary borings sealed on a single property. Temporary borings less than 25 feet in depth are exempt from the notification requirements in this chapter.

Sec. 14. Minnesota Statutes 2018, section 103I.601, subdivision 4, is amended to read:

Subd. 4. **Notification and map of borings.** (a) By ten days before beginning exploratory boring, an explorer must submit to the commissioner of health a notification of the proposed boring ~~on a form prescribed by the commissioner,~~ map and a fee of $275 ~~for each exploratory boring~~.

(b) By ten days before beginning exploratory boring, an explorer must submit to the commissioners of health and natural resources a county road map on a single sheet of paper that is 8-1/2 by 11 inches in size and having a scale of one-half inch equal to one mile, as prepared by the Department of Transportation, or a 7.5 minute series topographic map (1:24,000 scale), as prepared by the United States Geological Survey, showing the location of each proposed exploratory boring to the nearest estimated 40 acre parcel. Exploratory boring that is proposed on the map may not be commenced later than 180 days after submission of the map, unless a new map is submitted.

Sec. 15. Minnesota Statutes 2018, section 144.121, subdivision 1a, is amended to read:

Subd. 1a. **Fees for ionizing radiation-producing equipment.** (a) A facility with ionizing radiation-producing equipment must pay an annual initial or annual renewal registration fee consisting of a base facility fee of $100 and an additional fee for each radiation source, as follows:

| | |
|---|---|
| (1) medical or veterinary equipment | $ 100 |
| (2) dental x-ray equipment | $ 40 |
| (3) x-ray equipment not used on humans or animals | $ 100 |
| (4) devices with sources of ionizing radiation not used on humans or animals | $ 100 |
| (5) security screening system | $ 100 |

(b) A facility with radiation therapy and accelerator equipment must pay an annual registration fee of $500. A facility with an industrial accelerator must pay an annual registration fee of $150.

(c) Electron microscopy equipment is exempt from the registration fee requirements of this section.

(d) For purposes of this section, a security screening system means radiation-producing equipment designed and used for security screening of humans who are in the custody of a correctional or detention facility, and used by the facility to image and identify contraband items concealed within or on all sides of a human body. For purposes of this section, a correctional or detention facility is a facility licensed under section 241.021 and operated by a state agency or political subdivision charged with detection, enforcement, or incarceration in respect to state criminal and traffic laws.

Sec. 16. Minnesota Statutes 2018, section 144.121, is amended by adding a subdivision to read:

Subd. 9. **Exemption from examination requirements; operators of security screening systems.** (a) An employee of a correctional or detention facility who operates a security screening system and the facility in which the system is being operated are exempt from the requirements of subdivisions 5 and 6.

(b) An employee of a correctional or detention facility who operates a security screening system and the facility in which the system is being operated must meet the requirements of a variance to Minnesota Rules, parts 4732.0305 and 4732.0565, issued under Minnesota Rules, parts 4717.7000 to 4717.7050. This paragraph expires on December 31 of the year that the permanent rules adopted by the commissioner governing security screening systems are published in the State Register.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 17. Minnesota Statutes 2018, section 144.225, subdivision 2, is amended to read:

Subd. 2. **Data about births.** (a) Except as otherwise provided in this subdivision, data pertaining to the birth of a child to a woman who was not married to the child's father when the child was conceived nor when the child was born, including the original record of birth and the certified vital record, are confidential data. At the time of the birth of a child to a woman who was not married to the child's father when the child was conceived nor when

the child was born, the mother may designate demographic data pertaining to the birth as public. Notwithstanding the designation of the data as confidential, it may be disclosed:

(1) to a parent or guardian of the child;

(2) to the child when the child is 16 years of age or older;

(3) under paragraph (b) ~~or~~, (e), or (f); or

(4) pursuant to a court order. For purposes of this section, a subpoena does not constitute a court order.

(b) Unless the child is adopted, data pertaining to the birth of a child that are not accessible to the public become public data if 100 years have elapsed since the birth of the child who is the subject of the data, or as provided under section 13.10, whichever occurs first.

(c) If a child is adopted, data pertaining to the child's birth are governed by the provisions relating to adoption records, including sections 13.10, subdivision 5; 144.218, subdivision 1; 144.2252; and 259.89.

(d) The name and address of a mother under paragraph (a) and the child's date of birth may be disclosed to the county social services, tribal health department, or public health member of a family services collaborative for purposes of providing services under section 124D.23.

(e) The commissioner of human services shall have access to birth records for:

(1) the purposes of administering medical assistance and the MinnesotaCare program;

(2) child support enforcement purposes; and

(3) other public health purposes as determined by the commissioner of health.

(f) Tribal child support programs shall have access to birth records for child support enforcement purposes.

Sec. 18. Minnesota Statutes 2018, section 144.225, subdivision 2a, is amended to read:

Subd. 2a. **Health data associated with birth registration.** Information from which an identification of risk for disease, disability, or developmental delay in a mother or child can be made, that is collected in conjunction with birth registration or fetal death reporting, is private data as defined in section 13.02, subdivision 12. The commissioner may disclose to a tribal health department or community health board, as defined in section 145A.02, subdivision 5, health data associated with birth registration which identifies a mother or child at high risk for serious disease, disability, or developmental delay in order to assure

access to appropriate health, social, or educational services. Notwithstanding the designation of the private data, the commissioner of human services shall have access to health data associated with birth registration for:

(1) purposes of administering medical assistance and the MinnesotaCare program; and

(2) for other public health purposes as determined by the commissioner of health.

Sec. 19. Minnesota Statutes 2018, section 144.225, subdivision 7, is amended to read:

Subd. 7. **Certified birth or death record.** (a) The state registrar or local issuance office shall issue a certified birth or death record or a statement of no vital record found to an individual upon the individual's proper completion of an attestation provided by the commissioner and payment of the required fee:

(1) to a person who has a tangible interest in the requested vital record. A person who has a tangible interest is:

(i) the subject of the vital record;

(ii) a child of the subject;

(iii) the spouse of the subject;

(iv) a parent of the subject;

(v) the grandparent or grandchild of the subject;

(vi) if the requested record is a death record, a sibling of the subject;

(vii) the party responsible for filing the vital record;

(viii) the legal custodian, guardian or conservator, or health care agent of the subject;

(ix) a personal representative, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

(x) a successor of the subject, as defined in section 524.1-201, if the subject is deceased, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

(xi) if the requested record is a death record, a trustee of a trust by sworn affidavit of the fact that the certified copy is needed for the proper administration of the trust;

(xii) a person or entity who demonstrates that a certified vital record is necessary for the determination or protection of a personal or property right, pursuant to rules adopted by the commissioner; or

(xiii) an adoption agency in order to complete confidential postadoption searches as required by section 259.83;

(2) to any local, state, tribal, or federal governmental agency upon request if the certified vital record is necessary for the governmental agency to perform its authorized duties;

(3) to an attorney upon evidence of the attorney's license;

(4) pursuant to a court order issued by a court of competent jurisdiction. For purposes of this section, a subpoena does not constitute a court order; or

(5) to a representative authorized by a person under clauses (1) to (4).

(b) The state registrar or local issuance office shall also issue a certified death record to an individual described in paragraph (a), clause (1), items (ii) to (viii), if, on behalf of the individual, a licensed mortician furnishes the registrar with a properly completed attestation in the form provided by the commissioner within 180 days of the time of death of the subject of the death record. This paragraph is not subject to the requirements specified in Minnesota Rules, part 4601.2600, subpart 5, item B.

Sec. 20. Minnesota Statutes 2018, section 144.3831, subdivision 1, is amended to read:

Subdivision 1. **Fee setting.** The commissioner of health may assess an annual fee of ~~$6.36~~ $9.72 for every service connection to a public water supply that is owned or operated by a home rule charter city, a statutory city, a city of the first class, or a town. The commissioner of health may also assess an annual fee for every service connection served by a water user district defined in section 110A.02.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 21. **[144.397] STATEWIDE TOBACCO CESSATION SERVICES.**

(a) The commissioner of health shall administer, or contract for the administration of, statewide tobacco cessation services to assist Minnesotans who are seeking advice or services to help them quit using tobacco products. The commissioner shall establish statewide public awareness activities to inform the public of the availability of the services and encourage the public to utilize the services because of the dangers and harm of tobacco use and dependence.

(b) Services to be provided may include but are not limited to:

(1) telephone-based coaching and counseling;

(2) referrals;

(3) written materials mailed upon request;

(4) web-based texting or e-mail services; and

(5) free Food and Drug Administration-approved tobacco cessation medications.

(c) Services provided must be consistent with evidence-based best practices in tobacco cessation services. Services provided must be coordinated with health plan company tobacco prevention and cessation services that may be available to individuals depending on their health coverage.

Sec. 22. **[144.398] TOBACCO USE PREVENTION ACCOUNT.**

Subdivision 1. **Account created.** A tobacco use prevention account is created in the special revenue fund. The commissioner of management and budget shall deposit into the account all money recovered by or ordered to be paid to the state from one or more tobacco product manufacturers, including future annual payments and arrears payments, under the terms of a settlement or judgment from litigation regarding annual tobacco settlement payments on transferred tobacco brands.

Subd. 2. **Uses of money in account.** Each fiscal year, $12,000,000 from the tobacco use prevention account is appropriated to the commissioner of health for tobacco use prevention activities in section 144.396. In the event that the balance in the tobacco use prevention account is less than $12,000,000 on July 1, all money in the account on that date is appropriated to the commissioner of health for tobacco use prevention activities in section 144.396.

Subd. 3. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Consent judgment" has the meaning given in section 16A.98, subdivision 1, paragraph (f).

(c) "Litigation regarding annual tobacco settlement payments on transferred tobacco brands" means litigation between the state and certain tobacco product manufacturers related to the obligation of these manufacturers to make past and future annual tobacco settlement payments according to the settlement agreement and consent judgment in amounts that include tobacco brands transferred from one or more tobacco product manufacturers to another tobacco product manufacturer.

(d) "Settlement agreement" has the meaning given in section 16A.98, subdivision 1, paragraph (h).

**EFFECTIVE DATE.** This section is effective the day following final enactment and applies to settlements reached or judgments entered on or after that date.

Sec. 23. Minnesota Statutes 2018, section 144.412, is amended to read:

**144.412 PUBLIC POLICY.**

The purpose of sections 144.411 to 144.417 is to protect employees and the general public from the hazards of secondhand smoke and involuntary exposure to aerosol or vapor from electronic delivery devices by eliminating smoking in public places, places of employment, public transportation, and at public meetings.

Sec. 24. Minnesota Statutes 2018, section 144.413, subdivision 1, is amended to read:

Subdivision 1. **Scope.** As used in sections 144.411 to ~~144.416~~ 144.417, the terms defined in this section have the meanings given them.

Sec. 25. Minnesota Statutes 2018, section 144.413, subdivision 4, is amended to read:

Subd. 4. **Smoking.** "Smoking" means inhaling ~~or~~, exhaling ~~smoke from~~, burning, or carrying any lighted or heated cigar, cigarette, pipe, or any other lighted ~~tobacco or plant~~ or heated product containing, made, or derived from nicotine, tobacco, marijuana, or other plant, whether natural or synthetic, that is intended for inhalation. Smoking ~~also~~ includes ~~carrying a lighted cigar, cigarette, pipe, or any other lighted tobacco or plant product intended for inhalation~~ carrying or using an activated electronic delivery device, as defined in section 609.685.

Sec. 26. Minnesota Statutes 2018, section 144.414, subdivision 2, is amended to read:

Subd. 2. **Day care premises.** ~~(a)~~ Smoking is prohibited in a day care center licensed under Minnesota Rules, parts 9503.0005 to 9503.0170, or in a family home or in a group family day care provider home licensed under Minnesota Rules, parts 9502.0300 to 9502.0445, during its hours of operation. The proprietor of a family home or group family day care provider must disclose to parents or guardians of children cared for on the premises if the proprietor permits smoking outside of its hours of operation. Disclosure must include posting on the premises a conspicuous written notice and orally informing parents or guardians.

~~(b) For purposes of this subdivision, the definition of smoking includes the use of electronic cigarettes, including the inhaling and exhaling of vapor from any electronic delivery device as defined in section 609.685, subdivision 1.~~

Sec. 27. Minnesota Statutes 2018, section 144.414, subdivision 3, is amended to read:

Subd. 3. **Health care facilities and clinics.** (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws.

(b) Except as provided in section 246.0141, smoking by patients in a locked psychiatric unit may be allowed in a separated well-ventilated area in the unit under a policy established by the administrator of the program that allows the treating physician to approve smoking if, in the opinion of the treating physician, the benefits to be gained in obtaining patient cooperation with treatment outweigh the negative impacts of smoking.

~~(c) For purposes of this subdivision, the definition of smoking includes the use of electronic cigarettes, including the inhaling and exhaling of vapor from any electronic delivery device as defined in section 609.685, subdivision 1.~~

Sec. 28. Minnesota Statutes 2018, section 144.416, is amended to read:

**144.416 RESPONSIBILITIES OF PROPRIETORS.**

(a) The proprietor or other person, firm, limited liability company, corporation, or other entity that owns, leases, manages, operates, or otherwise controls the use of a public place, public transportation, place of employment, or public meeting shall make reasonable efforts to prevent smoking in the public place, public transportation, place of employment, or public meeting by:

(1) posting appropriate signs or by any other means which may be appropriate; and

(2) asking any person who smokes in an area where smoking is prohibited to refrain from smoking and, if the person does not refrain from smoking after being asked to do so, asking the person to leave. If the person refuses to leave, the proprietor, person, or entity in charge shall handle the situation consistent with lawful methods for handling other persons acting in a disorderly manner or as a trespasser.

(b) The proprietor or other person or entity in charge of a public place, public meeting, public transportation, or place of employment must not provide smoking equipment, including ashtrays or matches, in areas where smoking is prohibited. Nothing in this section prohibits the proprietor or other person or entity in charge from taking more stringent measures than those under sections 144.414 to 144.417 to protect individuals from secondhand smoke or from involuntary exposure to aerosol or vapor from electronic delivery devices. The

proprietor or other person or entity in charge of a restaurant or bar may not serve an individual who is in violation of sections 144.411 to 144.417.

Sec. 29. Minnesota Statutes 2018, section 144.4165, is amended to read:

**144.4165 TOBACCO PRODUCTS PROHIBITED IN PUBLIC SCHOOLS.**

No person shall at any time smoke, chew, or otherwise ingest tobacco ~~or a tobacco product~~, or ~~inhale or exhale vapor from~~ carry or use an activated electronic delivery device as defined in section 609.685, subdivision 1, in a public school, as defined in section 120A.05, subdivisions 9, 11, and 13, ~~and no person under the age of 18 shall possess any of these items~~ or in a charter school governed by chapter 124E. This prohibition extends to all facilities, whether owned, rented, or leased, and all vehicles that a school district owns, leases, rents, contracts for, or controls. Nothing in this section shall prohibit the lighting of tobacco by an adult as a part of a traditional Indian spiritual or cultural ceremony. For purposes of this section, an Indian is a person who is a member of an Indian tribe as defined in section 260.755, subdivision 12.

Sec. 30. Minnesota Statutes 2018, section 144.4167, subdivision 4, is amended to read:

Subd. 4. **Tobacco products shop.** Sections 144.414 to 144.417 do not prohibit the lighting, heating, or activation of tobacco in a tobacco products shop by a customer or potential customer for the specific purpose of sampling tobacco products. For the purposes of this subdivision, a tobacco products shop is a retail establishment ~~with~~ that cannot be entered at any time by persons younger than 21 years of age, that has an entrance door opening directly to the outside, and that derives more than 90 percent of its gross revenue from the sale of ~~loose~~ tobacco, ~~plants, or herbs and cigars, cigarettes, pipes, and other smoking devices for burning tobacco and related smoking accessories~~ tobacco-related devices, and electronic delivery devices, as defined in section 609.685, and in which the sale of other products is merely incidental. "Tobacco products shop" does not include a tobacco department or section of any individual business establishment with any type of liquor, food, or restaurant license.

Sec. 31. Minnesota Statutes 2018, section 144.417, subdivision 4, is amended to read:

Subd. 4. **Local government ordinances.** (a) Nothing in sections 144.414 to 144.417 prohibits a statutory or home rule charter city or county from enacting and enforcing more stringent measures to protect individuals from secondhand smoke or from involuntary exposure to aerosol or vapor from electronic delivery devices.

(b) Except as provided in sections 144.411 to 144.417, smoking is permitted outside of restaurants, bars, and bingo halls unless limited or prohibited by restrictions adopted in accordance with paragraph (a).

Sec. 32. Minnesota Statutes 2018, section 144.562, subdivision 2, is amended to read:

Subd. 2. **Eligibility for license condition.** (a) A hospital is not eligible to receive a license condition for swing beds unless (1) it either has a licensed bed capacity of less than 50 beds defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66, or it has a licensed bed capacity of 50 beds or more and has swing beds that were approved for Medicare reimbursement before May 1, 1985, or it has a licensed bed capacity of less than 65 beds and the available nursing homes within 50 miles have had, in the aggregate, an average occupancy rate of 96 percent or higher in the most recent two years as documented on the statistical reports to the Department of Health; and (2) it is located in a rural area as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66.

(b) Except for those critical access hospitals established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, eligible hospitals are allowed a total of ~~2,000~~ 9,125 days of swing bed use per year as provided in federal law. Critical access hospitals that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, are allowed swing bed use as provided in federal law.

~~(c) Except for critical access hospitals that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, the commissioner of health may approve swing bed use beyond 2,000 days as long as there are no Medicare certified skilled nursing facility beds available within 25 miles of that hospital that are willing to admit the patient and the patient agrees to the referral being sent to the skilled nursing facility. Critical access hospitals exceeding 2,000 swing bed days must maintain documentation that they have contacted skilled nursing facilities within 25 miles to determine if any skilled nursing facility beds are available that are willing to admit the patient and the patient agrees to the referral being sent to the skilled nursing facility.~~

~~(d) After reaching 2,000 days of swing bed use in a year, an eligible hospital to which this limit applies may admit six additional patients to swing beds each year without seeking approval from the commissioner or being in violation of this subdivision. These six swing~~

~~bed admissions are exempt from the limit of 2,000 annual swing bed days for hospitals subject to this limit.~~

~~(e) A health care system that is in full compliance with this subdivision may allocate its total limit of swing bed days among the hospitals within the system, provided that no hospital in the system without an attached nursing home may exceed 2,000 swing bed days per year.~~

Sec. 33. Minnesota Statutes 2018, section 144.966, subdivision 2, is amended to read:

Subd. 2. **Newborn Hearing Screening Advisory Committee.** (a) The commissioner of health shall establish a Newborn Hearing Screening Advisory Committee to advise and assist the Department of Health and the Department of Education in:

(1) developing protocols and timelines for screening, rescreening, and diagnostic audiological assessment and early medical, audiological, and educational intervention services for children who are deaf or hard-of-hearing;

(2) designing protocols for tracking children from birth through age three that may have passed newborn screening but are at risk for delayed or late onset of permanent hearing loss;

(3) designing a technical assistance program to support facilities implementing the screening program and facilities conducting rescreening and diagnostic audiological assessment;

(4) designing implementation and evaluation of a system of follow-up and tracking; and

(5) evaluating program outcomes to increase effectiveness and efficiency and ensure culturally appropriate services for children with a confirmed hearing loss and their families.

(b) The commissioner of health shall appoint at least one member from each of the following groups with no less than two of the members being deaf or hard-of-hearing:

(1) a representative from a consumer organization representing culturally deaf persons;

(2) a parent with a child with hearing loss representing a parent organization;

(3) a consumer from an organization representing oral communication options;

(4) a consumer from an organization representing cued speech communication options;

(5) an audiologist who has experience in evaluation and intervention of infants and young children;

(6) a speech-language pathologist who has experience in evaluation and intervention of infants and young children;

(7) two primary care providers who have experience in the care of infants and young children, one of which shall be a pediatrician;

(8) a representative from the early hearing detection intervention teams;

(9) a representative from the Department of Education resource center for the deaf and hard-of-hearing or the representative's designee;

(10) a representative of the Commission of the Deaf, DeafBlind and Hard of Hearing;

(11) a representative from the Department of Human Services Deaf and Hard-of-Hearing Services Division;

(12) one or more of the Part C coordinators from the Department of Education, the Department of Health, or the Department of Human Services or the department's designees;

(13) the Department of Health early hearing detection and intervention coordinators;

(14) two birth hospital representatives from one rural and one urban hospital;

(15) a pediatric geneticist;

(16) an otolaryngologist;

(17) a representative from the Newborn Screening Advisory Committee under this subdivision; ~~and~~

(18) a representative of the Department of Education regional low-incidence facilitators~~.~~;

(19) a representative from the deaf mentor program; and

(20) a representative of the Minnesota State Academy for the Deaf from the Minnesota State Academies staff.

The commissioner must complete the initial appointments required under this subdivision by September 1, 2007, and the initial appointments under clauses (19) and (20) by September 1, 2019.

(c) The Department of Health member shall chair the first meeting of the committee. At the first meeting, the committee shall elect a chair from its membership. The committee shall meet at the call of the chair, at least four times a year. The committee shall adopt written bylaws to govern its activities. The Department of Health shall provide technical and administrative support services as required by the committee. These services shall include technical support from individuals qualified to administer infant hearing screening, rescreening, and diagnostic audiological assessments.

Members of the committee shall receive no compensation for their service, but shall be reimbursed as provided in section 15.059 for expenses incurred as a result of their duties as members of the committee.

(d) By February 15, 2015, and by February 15 of the odd-numbered years after that date, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and data privacy on the activities of the committee that have occurred during the past two years.

(e) This subdivision expires June 30, ~~2019~~ 2025.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 34. Minnesota Statutes 2018, section 144.99, subdivision 1, is amended to read:

Subdivision 1. **Remedies available.** The provisions of chapters 103I and 157 and sections 115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12), (13), (14), and (15); 144.1201 to 144.1204; 144.121; 144.1215; 144.1222; 144.35; 144.381 to 144.385; 144.411 to 144.417; 144.495; 144.71 to 144.74; 144.9501 to 144.9512; 144.97 to 144.98; 144.992; 152.22 to 152.37; 326.70 to 326.785; 327.10 to 327.131; and 327.14 to 327.28 and all rules, orders, stipulation agreements, settlements, compliance agreements, licenses, registrations, certificates, and permits adopted or issued by the department or under any other law now in force or later enacted for the preservation of public health may, in addition to provisions in other statutes, be enforced under this section.

Sec. 35. Minnesota Statutes 2018, section 144A.43, subdivision 11, is amended to read:

Subd. 11. **Medication administration.** "Medication administration" means performing a set of tasks ~~to ensure a client takes medications, and includes~~ that include the following:

(1) checking the client's medication record;

(2) preparing the medication as necessary;

(3) administering the medication to the client;

(4) documenting the administration or reason for not administering the medication; and

(5) reporting to a registered nurse or appropriate licensed health professional any concerns about the medication, the client, or the client's refusal to take the medication.

Sec. 36. Minnesota Statutes 2018, section 144A.43, is amended by adding a subdivision to read:

Subd. 12a. **Medication reconciliation.** "Medication reconciliation" means the process of identifying the most accurate list of all medications the client is taking, including the name, dosage, frequency, and route by comparing the client record to an external list of medications obtained from the client, hospital, prescriber, or other provider.

Sec. 37. Minnesota Statutes 2018, section 144A.43, subdivision 30, is amended to read:

Subd. 30. **Standby assistance.** "Standby assistance" means the presence of another person ~~within arm's reach to minimize the risk of injury while performing daily activities through physical intervention or cuing~~ to assist a client with an assistive task by providing cues, oversight, and minimal physical assistance.

Sec. 38. Minnesota Statutes 2018, section 144A.472, subdivision 5, is amended to read:

Subd. 5. ~~**Transfers prohibited;**~~ **Changes in ownership.** ~~Any~~ (a) A home care license issued by the commissioner may not be transferred to another party. Before acquiring ownership of or a controlling interest in a home care provider business, a prospective ~~applicant~~ owner must apply for a new ~~temporary~~ license. A change of ownership is a transfer of operational control ~~to a different business entity~~ of the home care provider business and includes:

(1) transfer of the business to a different or new corporation;

(2) in the case of a partnership, the dissolution or termination of the partnership under chapter 323A, with the business continuing by a successor partnership or other entity;

(3) relinquishment of control of the provider to another party, including to a contract management firm that is not under the control of the owner of the business' assets;

(4) transfer of the business by a sole proprietor to another party or entity; or

(5) ~~in the case of a privately held corporation, the change in~~ transfer of ownership or control of 50 percent or more of the ~~outstanding voting stock~~ controlling interest of a home care provider business not covered by clauses (1) to (4).

(b) An employee who was employed by the previous owner of the home care provider business prior to the effective date of a change in ownership under paragraph (a), and who will be employed by the new owner in the same or a similar capacity, shall be treated as if no change in employer occurred, with respect to orientation, training, tuberculosis testing,

background studies, and competency testing and training on the policies identified in subdivision 1, clause (14), and subdivision 2, if applicable.

(c) Notwithstanding paragraph (b), a new owner of a home care provider business must ensure that employees of the provider receive and complete training and testing on any provisions of policies that differ from those of the previous owner within 90 days after the date of the change in ownership.

Sec. 39. Minnesota Statutes 2018, section 144A.472, subdivision 7, is amended to read:

Subd. 7. **Fees; application, change of ownership, ~~and~~ renewal, and failure to notify.** (a) An initial applicant seeking temporary home care licensure must submit the following application fee to the commissioner along with a completed application:

(1) for a basic home care provider, $2,100; or

(2) for a comprehensive home care provider, $4,200.

(b) A home care provider who is filing a change of ownership as required under subdivision 5 must submit the following application fee to the commissioner, along with the documentation required for the change of ownership:

(1) for a basic home care provider, $2,100; or

(2) for a comprehensive home care provider, $4,200.

(c) For the period ending June 30, 2018, a home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted, according to the following schedule:

**License Renewal Fee**

| **Provider Annual Revenue** | **Fee** |
|---|---|
| greater than $1,500,000 | $6,625 |
| greater than $1,275,000 and no more than $1,500,000 | $5,797 |
| greater than $1,100,000 and no more than $1,275,000 | $4,969 |
| greater than $950,000 and no more than $1,100,000 | $4,141 |
| greater than $850,000 and no more than $950,000 | $3,727 |
| greater than $750,000 and no more than $850,000 | $3,313 |
| greater than $650,000 and no more than $750,000 | $2,898 |

| | |
|---|---|
| greater than $550,000 and no more than $650,000 | $2,485 |
| greater than $450,000 and no more than $550,000 | $2,070 |
| greater than $350,000 and no more than $450,000 | $1,656 |
| greater than $250,000 and no more than $350,000 | $1,242 |
| greater than $100,000 and no more than $250,000 | $828 |
| greater than $50,000 and no more than $100,000 | $500 |
| greater than $25,000 and no more than $50,000 | $400 |
| no more than $25,000 | $200 |

(d) For the period between July 1, 2018, and June 30, 2020, a home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner in an amount that is ten percent higher than the applicable fee in paragraph (c). A home care provider's fee shall be based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted.

(e) Beginning July 1, 2020, a home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted, according to the following schedule:

**License Renewal Fee**

| **Provider Annual Revenue** | **Fee** |
|---|---|
| greater than $1,500,000 | $7,651 |
| greater than $1,275,000 and no more than $1,500,000 | $6,695 |
| greater than $1,100,000 and no more than $1,275,000 | $5,739 |
| greater than $950,000 and no more than $1,100,000 | $4,783 |
| greater than $850,000 and no more than $950,000 | $4,304 |
| greater than $750,000 and no more than $850,000 | $3,826 |
| greater than $650,000 and no more than $750,000 | $3,347 |
| greater than $550,000 and no more than $650,000 | $2,870 |
| greater than $450,000 and no more than $550,000 | $2,391 |
| greater than $350,000 and no more than $450,000 | $1,913 |
| greater than $250,000 and no more than $350,000 | $1,434 |
| greater than $100,000 and no more than $250,000 | $957 |
| greater than $50,000 and no more than $100,000 | $577 |
| greater than $25,000 and no more than $50,000 | $462 |
| no more than $25,000 | $231 |

(f) If requested, the home care provider shall provide the commissioner information to verify the provider's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(g) At each annual renewal, a home care provider may elect to pay the highest renewal fee for its license category, and not provide annual revenue information to the commissioner.

(h) A temporary license or license applicant, or temporary licensee or licensee that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee, shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

(i) The fee for failure to comply with the notification requirements of section 144A.473, subdivision 2, paragraph (c), is $1,000.

(j) Fees and penalties collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund. All fees are nonrefundable. Fees collected under paragraphs (c), (d), and (e) are nonrefundable even if received before July 1, 2017, for temporary licenses or licenses being issued effective July 1, 2017, or later.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 40. Minnesota Statutes 2018, section 144A.473, is amended to read:

**144A.473 ISSUANCE OF TEMPORARY LICENSE AND LICENSE RENEWAL.**

Subdivision 1. **Temporary license and renewal of license.** (a) The department shall review each application to determine the applicant's knowledge of and compliance with Minnesota home care regulations. Before granting a temporary license or renewing a license, the commissioner may further evaluate the applicant or licensee by requesting additional information or documentation or by conducting an on-site survey of the applicant to determine compliance with sections 144A.43 to 144A.482.

(b) Within 14 calendar days after receiving an application for a license, the commissioner shall acknowledge receipt of the application in writing. The acknowledgment must indicate whether the application appears to be complete or whether additional information is required before the application will be considered complete.

(c) Within 90 days after receiving a complete application, the commissioner shall issue a temporary license, renew the license, or deny the license.

(d) The commissioner shall issue a license that contains the home care provider's name, address, license level, expiration date of the license, and unique license number. All licenses,

except for temporary licenses issued under subdivision 2, are valid for up to one year from the date of issuance.

Subd. 2. **Temporary license.** (a) For new license applicants, the commissioner shall issue a temporary license for either the basic or comprehensive home care level. A temporary license is effective for up to one year from the date of issuance, except that a temporary license may be extended according to subdivision 3. Temporary licensees must comply with sections 144A.43 to 144A.482.

(b) During the temporary license ~~year~~ period, the commissioner shall survey the temporary licensee within 90 calendar days after the commissioner is notified or has evidence that the temporary licensee is providing home care services.

(c) Within five days of beginning the provision of services, the temporary licensee must notify the commissioner that it is serving clients. The notification to the commissioner may be mailed or e-mailed to the commissioner at the address provided by the commissioner. If the temporary licensee does not provide home care services during the temporary license ~~year~~ period, then the temporary license expires at the end of the ~~year~~ period and the applicant must reapply for a temporary home care license.

(d) A temporary licensee may request a change in the level of licensure prior to being surveyed and granted a license by notifying the commissioner in writing and providing additional documentation or materials required to update or complete the changed temporary license application. The applicant must pay the difference between the application fees when changing from the basic level to the comprehensive level of licensure. No refund will be made if the provider chooses to change the license application to the basic level.

(e) If the temporary licensee notifies the commissioner that the licensee has clients within 45 days prior to the temporary license expiration, the commissioner may extend the temporary license for up to 60 days in order to allow the commissioner to complete the on-site survey required under this section and follow-up survey visits.

Subd. 3. **Temporary licensee survey.** (a) If the temporary licensee is in substantial compliance with the survey, the commissioner shall issue either a basic or comprehensive home care license. If the temporary licensee is not in substantial compliance with the survey, the commissioner shall either: (1) not issue a ~~basic or comprehensive~~ license and ~~there will be no contested hearing right under chapter 14.~~ terminate the temporary license; or (2) extend the temporary license for a period not to exceed 90 days and apply conditions, as permitted under section 144A.475, subdivision 2, to the extension of a temporary license. If the temporary licensee is not in substantial compliance with the survey within the time

period of the extension, or if the temporary licensee does not satisfy the license conditions, the commissioner may deny the license.

(b) If the temporary licensee whose basic or comprehensive license has been denied or extended with conditions disagrees with the conclusions of the commissioner, then the temporary licensee may request a reconsideration by the commissioner or commissioner's designee. The reconsideration request process must be conducted internally by the commissioner or commissioner's designee, and chapter 14 does not apply.

(c) The temporary licensee requesting reconsideration must make the request in writing and must list and describe the reasons why the temporary licensee disagrees with the decision to deny the basic or comprehensive home care license or the decision to extend the temporary license with conditions.

(d) The reconsideration request and supporting documentation must be received by the commissioner within 15 calendar days after the date the temporary licensee receives the correction order.

(e) A temporary licensee whose license is denied, is permitted to continue operating as a home care provider during the period of time when:

(1) a reconsideration request is in process;

(2) an extension of a temporary license is being negotiated;

(3) the placement of conditions on a temporary license is being negotiated; or

(4) a transfer of home care clients from the temporary licensee to a new home care provider is in process.

(f) A temporary licensee whose license is denied must comply with the requirements for notification and transfer of clients in section 144A.475, subdivision 5.

Sec. 41. Minnesota Statutes 2018, section 144A.474, subdivision 2, is amended to read:

Subd. 2. **Types of home care surveys.** (a) "Initial full survey" means the survey of a new temporary licensee conducted after the department is notified or has evidence that the temporary licensee is providing home care services to determine if the provider is in compliance with home care requirements. Initial full surveys must be completed within 14 months after the department's issuance of a temporary basic or comprehensive license.

(b) "Change in ownership survey" means a full survey of a new licensee due to a change in ownership. Change in ownership surveys must be completed within six months after the department's issuance of a new license due to a change in ownership.

(c) "Core survey" means periodic inspection of home care providers to determine ongoing compliance with the home care requirements, focusing on the essential health and safety requirements. Core surveys are available to licensed home care providers who have been licensed for three years and surveyed at least once in the past three years with the latest survey having no widespread violations beyond Level 1 as provided in subdivision 11. Providers must also not have had any substantiated licensing complaints, substantiated complaints against the agency under the Vulnerable Adults Act or Maltreatment of Minors Act, or an enforcement action as authorized in section 144A.475 in the past three years.

(1) The core survey for basic home care providers must review compliance in the following areas:

(i) reporting of maltreatment;

(ii) orientation to and implementation of the home care bill of rights;

(iii) statement of home care services;

(iv) initial evaluation of clients and initiation of services;

(v) client review and monitoring;

(vi) service plan implementation and changes to the service plan;

(vii) client complaint and investigative process;

(viii) competency of unlicensed personnel; and

(ix) infection control.

(2) For comprehensive home care providers, the core survey must include everything in the basic core survey plus these areas:

(i) delegation to unlicensed personnel;

(ii) assessment, monitoring, and reassessment of clients; and

(iii) medication, treatment, and therapy management.

~~(c)~~ (d) "Full survey" means the periodic inspection of home care providers to determine ongoing compliance with the home care requirements that cover the core survey areas and all the legal requirements for home care providers. A full survey is conducted for all temporary licensees ~~and~~, for licensees that receive licenses due to an approved change in ownership, for providers who do not meet the requirements needed for a core survey, and when a surveyor identifies unacceptable client health or safety risks during a core survey. A full survey must include all the tasks identified as part of the core survey and any additional

review deemed necessary by the department, including additional observation, interviewing, or records review of additional clients and staff.

~~(d)~~ (e) "Follow-up surveys" means surveys conducted to determine if a home care provider has corrected deficient issues and systems identified during a core survey, full survey, or complaint investigation. Follow-up surveys may be conducted via phone, e-mail, fax, mail, or on-site reviews. Follow-up surveys, other than complaint surveys, shall be concluded with an exit conference and written information provided on the process for requesting a reconsideration of the survey results.

~~(e)~~ (f) Upon receiving information alleging that a home care provider has violated or is currently violating a requirement of sections 144A.43 to 144A.482, the commissioner shall investigate the complaint according to sections 144A.51 to 144A.54.

Sec. 42. Minnesota Statutes 2018, section 144A.475, subdivision 1, is amended to read:

Subdivision 1. **Conditions.** (a) The commissioner may refuse to grant a temporary license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the home care provider or owner or managerial official of the home care provider:

(1) is in violation of, or during the term of the license has violated, any of the requirements in sections 144A.471 to 144A.482;

(2) permits, aids, or abets the commission of any illegal act in the provision of home care;

(3) performs any act detrimental to the health, safety, and welfare of a client;

(4) obtains the license by fraud or misrepresentation;

(5) knowingly made or makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;

(6) denies representatives of the department access to any part of the home care provider's books, records, files, or employees;

(7) interferes with or impedes a representative of the department in contacting the home care provider's clients;

(8) interferes with or impedes a representative of the department in the enforcement of this chapter or has failed to fully cooperate with an inspection, survey, or investigation by the department;

(9) destroys or makes unavailable any records or other evidence relating to the home care provider's compliance with this chapter;

(10) refuses to initiate a background study under section 144.057 or 245A.04;

(11) fails to timely pay any fines assessed by the department;

(12) violates any local, city, or township ordinance relating to home care services;

(13) has repeated incidents of personnel performing services beyond their competency level; or

(14) has operated beyond the scope of the home care provider's license level.

(b) A violation by a contractor providing the home care services of the home care provider is a violation by the home care provider.

Sec. 43. Minnesota Statutes 2018, section 144A.475, subdivision 2, is amended to read:

Subd. 2. **Terms to suspension or conditional license.** (a) A suspension or conditional license designation may include terms that must be completed or met before a suspension or conditional license designation is lifted. A conditional license designation may include restrictions or conditions that are imposed on the provider. Terms for a suspension or conditional license may include one or more of the following and the scope of each will be determined by the commissioner:

(1) requiring a consultant to review, evaluate, and make recommended changes to the home care provider's practices and submit reports to the commissioner at the cost of the home care provider;

(2) requiring supervision of the home care provider or staff practices at the cost of the home care provider by an unrelated person who has sufficient knowledge and qualifications to oversee the practices and who will submit reports to the commissioner;

(3) requiring the home care provider or employees to obtain training at the cost of the home care provider;

(4) requiring the home care provider to submit reports to the commissioner;

(5) prohibiting the home care provider from taking any new clients for a period of time; or

(6) any other action reasonably required to accomplish the purpose of this subdivision and section 144A.45, subdivision 2.

(b) A home care provider subject to this subdivision may continue operating during the period of time home care clients are being transferred to other providers.

Sec. 44. Minnesota Statutes 2018, section 144A.475, subdivision 5, is amended to read:

Subd. 5. **Plan required.** (a) The process of suspending or revoking a license must include a plan for transferring affected clients to other providers by the home care provider, which will be monitored by the commissioner. Within three business days of being notified of the final revocation or suspension action, the home care provider shall provide the commissioner, the lead agencies as defined in section 256B.0911, and the ombudsman for long-term care with the following information:

(1) a list of all clients, including full names and all contact information on file;

(2) a list of each client's representative or emergency contact person, including full names and all contact information on file;

(3) the location or current residence of each client;

(4) the payor sources for each client, including payor source identification numbers; and

(5) for each client, a copy of the client's service plan, and a list of the types of services being provided.

(b) The revocation or suspension notification requirement is satisfied by mailing the notice to the address in the license record. The home care provider shall cooperate with the commissioner and the lead agencies during the process of transferring care of clients to qualified providers. Within three business days of being notified of the final revocation or suspension action, the home care provider must notify and disclose to each of the home care provider's clients, or the client's representative or emergency contact persons, that the commissioner is taking action against the home care provider's license by providing a copy of the revocation or suspension notice issued by the commissioner.

(c) A home care provider subject to this subdivision may continue operating during the period of time home care clients are being transferred to other providers.

Sec. 45. Minnesota Statutes 2018, section 144A.476, subdivision 1, is amended to read:

Subdivision 1. **Prior criminal convictions; owner and managerial officials.** (a) Before the commissioner issues a temporary license, issues a license as a result of an approved change in ownership, or renews a license, an owner or managerial official is required to complete a background study under section 144.057. No person may be involved in the

management, operation, or control of a home care provider if the person has been disqualified under chapter 245C. If an individual is disqualified under section 144.057 or chapter 245C, the individual may request reconsideration of the disqualification. If the individual requests reconsideration and the commissioner sets aside or rescinds the disqualification, the individual is eligible to be involved in the management, operation, or control of the provider. If an individual has a disqualification under section 245C.15, subdivision 1, and the disqualification is affirmed, the individual's disqualification is barred from a set aside, and the individual must not be involved in the management, operation, or control of the provider.

(b) For purposes of this section, owners of a home care provider subject to the background check requirement are those individuals whose ownership interest provides sufficient authority or control to affect or change decisions related to the operation of the home care provider. An owner includes a sole proprietor, a general partner, or any other individual whose individual ownership interest can affect the management and direction of the policies of the home care provider.

(c) For the purposes of this section, managerial officials subject to the background check requirement are individuals who provide direct contact as defined in section 245C.02, subdivision 11, or individuals who have the responsibility for the ongoing management or direction of the policies, services, or employees of the home care provider. Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.

(d) The department shall not issue any license if the applicant or owner or managerial official has been unsuccessful in having a background study disqualification set aside under section 144.057 and chapter 245C; if the owner or managerial official, as an owner or managerial official of another home care provider, was substantially responsible for the other home care provider's failure to substantially comply with sections 144A.43 to 144A.482; or if an owner that has ceased doing business, either individually or as an owner of a home care provider, was issued a correction order for failing to assist clients in violation of this chapter.

Sec. 46. Minnesota Statutes 2018, section 144A.479, subdivision 7, is amended to read:

Subd. 7. **Employee records.** The home care provider must maintain current records of each paid employee, regularly scheduled volunteers providing home care services, and of each individual contractor providing home care services. The records must include the following information:

(1) evidence of current professional licensure, registration, or certification, if licensure, registration, or certification is required by this statute or other rules;

(2) records of orientation, required annual training and infection control training, and competency evaluations;

(3) current job description, including qualifications, responsibilities, and identification of staff providing supervision;

(4) documentation of annual performance reviews which identify areas of improvement needed and training needs;

(5) for individuals providing home care services, verification that ~~required~~ any health screenings required by infection control programs established under section 144A.4798 have taken place and the dates of those screenings; and

(6) documentation of the background study as required under section 144.057.

Each employee record must be retained for at least three years after a paid employee, home care volunteer, or contractor ceases to be employed by or under contract with the home care provider. If a home care provider ceases operation, employee records must be maintained for three years.

Sec. 47. Minnesota Statutes 2018, section 144A.4791, subdivision 1, is amended to read:

Subdivision 1. **Home care bill of rights; notification to client.** (a) The home care provider shall provide the client or the client's representative a written notice of the rights under section 144A.44 before the ~~initiation of~~ date that services are first provided to that client. The provider shall make all reasonable efforts to provide notice of the rights to the client or the client's representative in a language the client or client's representative can understand.

(b) In addition to the text of the home care bill of rights in section 144A.44, subdivision 1, the notice shall also contain the following statement describing how to file a complaint with these offices.

"If you have a complaint about the provider or the person providing your home care services, you may call, write, or visit the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities."

The statement should include the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the

Minnesota Department of Health, the Office of the Ombudsman for Long-Term Care, and the Office of the Ombudsman for Mental Health and Developmental Disabilities. The statement should also include the home care provider's name, address, e-mail, telephone number, and name or title of the person at the provider to whom problems or complaints may be directed. It must also include a statement that the home care provider will not retaliate because of a complaint.

(c) The home care provider shall obtain written acknowledgment of the client's receipt of the home care bill of rights or shall document why an acknowledgment cannot be obtained. The acknowledgment may be obtained from the client or the client's representative. Acknowledgment of receipt shall be retained in the client's record.

Sec. 48. Minnesota Statutes 2018, section 144A.4791, subdivision 3, is amended to read:

Subd. 3. **Statement of home care services.** Prior to the ~~initiation of~~ date that services are first provided to the client, a home care provider must provide to the client or the client's representative a written statement which identifies if the provider has a basic or comprehensive home care license, the services the provider is authorized to provide, and which services the provider cannot provide under the scope of the provider's license. The home care provider shall obtain written acknowledgment from the clients that the provider has provided the statement or must document why the provider could not obtain the acknowledgment.

Sec. 49. Minnesota Statutes 2018, section 144A.4791, subdivision 6, is amended to read:

Subd. 6. **Initiation of services.** When a provider ~~initiates~~ provides home care services ~~and~~ to a client before the individualized review or assessment by a licensed health professional or registered nurse as required in subdivisions 7 and 8 ~~has not been~~ is completed, the ~~provider~~ licensed health professional or registered nurse must complete a temporary plan ~~and agreement~~ with the client ~~for services~~ and orient staff assigned to deliver services as identified in the temporary plan.

Sec. 50. Minnesota Statutes 2018, section 144A.4791, subdivision 7, is amended to read:

Subd. 7. **Basic individualized client review and monitoring.** (a) When services being provided are basic home care services, an individualized initial review of the client's needs and preferences must be conducted at the client's residence with the client or client's representative. This initial review must be completed within 30 days after the ~~initiation of the~~ date that home care services are first provided.

(b) Client monitoring and review must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the date of the last review. The monitoring and review may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs.

Sec. 51. Minnesota Statutes 2018, section 144A.4791, subdivision 8, is amended to read:

Subd. 8. **Comprehensive assessment, monitoring, and reassessment.** (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within five days after ~~initiation of~~ the date that home care services are first provided.

(b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after ~~initiation of~~ the date that home care services are first provided.

(c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs.

Sec. 52. Minnesota Statutes 2018, section 144A.4791, subdivision 9, is amended to read:

Subd. 9. **Service plan, implementation, and revisions to service plan.** (a) No later than 14 days after the ~~initiation of~~ date that home care services are first provided, a home care provider shall finalize a current written service plan.

(b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care.

(c) The home care provider must implement and provide all services required by the current service plan.

(d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable.

(e) Staff providing home care services must be informed of the current written service plan.

(f) The service plan must include:

(1) a description of the home care services to be provided, the fees for services, and the frequency of each service, according to the client's current review or assessment and client preferences;

(2) the identification of the staff or categories of staff who will provide the services;

(3) the schedule and methods of monitoring reviews or assessments of the client;

(4) ~~the frequency of sessions of supervision of staff and type of personnel who will supervise staff; and~~ the schedule and methods of monitoring staff providing home care services; and

(5) a contingency plan that includes:

(i) the action to be taken by the home care provider and by the client or client's representative if the scheduled service cannot be provided;

(ii) information and a method for a client or client's representative to contact the home care provider;

(iii) names and contact information of persons the client wishes to have notified in an emergency or if there is a significant adverse change in the client's condition~~, including identification of and information as to who has authority to sign for the client in an emergency~~; and

(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the client under those chapters.

Sec. 53. Minnesota Statutes 2018, section 144A.4792, subdivision 1, is amended to read:

Subdivision 1. **Medication management services; comprehensive home care license.** (a) This subdivision applies only to home care providers with a comprehensive home care license that provide medication management services to clients. Medication management services may not be provided by a home care provider who has a basic home care license.

(b) A comprehensive home care provider who provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines.

(c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and client and client representative, if any; disposing of unused medications; and educating clients and client representatives about medications. When controlled substances are being managed, stored, and secured by the comprehensive home care provider, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 22.

Sec. 54. Minnesota Statutes 2018, section 144A.4792, subdivision 2, is amended to read:

Subd. 2. **Provision of medication management services.** (a) For each client who requests medication management services, the comprehensive home care provider shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the client. The assessment must include an identification and review of all medications the client is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.

(b) The assessment must:

(1) identify interventions needed in management of medications to prevent diversion of medication by the client or others who may have access to the medications; and

(2) provide instructions to the client or client's representative on interventions to manage the client's medications and prevent diversion of medications.

"Diversion of medications" means the misuse, theft, or illegal or improper disposition of medications.

Sec. 55. Minnesota Statutes 2018, section 144A.4792, subdivision 5, is amended to read:

Subd. 5. **Individualized medication management plan.** (a) For each client receiving medication management services, the comprehensive home care provider must prepare and include in the service plan a written statement of the medication management services that will be provided to the client. The provider must develop and maintain a current individualized medication management record for each client based on the client's assessment that must contain the following:

(1) a statement describing the medication management services that will be provided;

(2) a description of storage of medications based on the client's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;

(3) documentation of specific client instructions relating to the administration of medications;

(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;

(5) identification of medication management tasks that may be delegated to unlicensed personnel;

(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and

(7) any client-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.

(b) The medication management record must be current and updated when there are any changes.

(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.

Sec. 56. Minnesota Statutes 2018, section 144A.4792, subdivision 10, is amended to read:

Subd. 10. **Medication management for clients who will be away from home.** (a) A home care provider who is providing medication management services to the client and controls the client's access to the medications must develop and implement policies and procedures for giving accurate and current medications to clients for planned or unplanned times away from home according to the client's individualized medication management plan. The policy and procedures must state that:

(1) for planned time away, the medications must be obtained from the pharmacy or set up by ~~the registered~~ a licensed nurse according to appropriate state and federal laws and nursing standards of practice;

(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall give the client or client's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed ~~120 hours~~ seven calendar days;

(3) the client or client's representative must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances;

(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the client's name and the dates and times that the medications are scheduled; and

(5) the client or client's representative must be provided in writing the home care provider's name and information on how to contact the home care provider.

(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:

(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to clients; and

(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the client. The procedures must address:

(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;

(ii) how the container or containers must be labeled;

(iii) the written information about the medications to be given to the client or client's representative;

(iv) how the unlicensed staff must document in the client's record that medications have been given to the client or the client's representative, including documenting the date the medications were given to the client or the client's representative and who received the medications, the person who gave the medications to the client, the number of medications that were given to the client, and other required information;

(v) how the registered nurse shall be notified that medications have been given to the client or client's representative and whether the registered nurse needs to be contacted before the medications are given to the client or the client's representative; ~~and~~

(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel~~.~~; and

(vii) how the unlicensed staff must document in the client's record any unused medications that are returned to the provider, including the name of each medication and the doses of each returned medication.

Sec. 57. Minnesota Statutes 2018, section 144A.4793, subdivision 6, is amended to read:

Subd. 6. **Treatment and therapy orders ~~or prescriptions~~.** There must be an up-to-date written or electronically recorded order ~~or prescription~~ from an authorized prescriber for all treatments and therapies. The order must contain the name of the client, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.

Sec. 58. Minnesota Statutes 2018, section 144A.4796, subdivision 2, is amended to read:

Subd. 2. **Content.** (a) The orientation must contain the following topics:

(1) an overview of sections 144A.43 to 144A.4798;

(2) introduction and review of all the provider's policies and procedures related to the provision of home care services by the individual staff person;

(3) handling of emergencies and use of emergency services;

(4) compliance with and reporting of the maltreatment of minors or vulnerable adults under sections 626.556 and 626.557;

(5) home care bill of rights under section 144A.44;

(6) handling of clients' complaints, reporting of complaints, and where to report complaints including information on the Office of Health Facility Complaints and the Common Entry Point;

(7) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county managed care advocates, or other relevant advocacy services; and

(8) review of the types of home care services the employee will be providing and the provider's scope of licensure.

(b) In addition to the topics listed in paragraph (a), orientation may also contain training on providing services to clients with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research-based, may include online training, and must include training on one or more of the following topics:

(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;

(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or

(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

Sec. 59. Minnesota Statutes 2018, section 144A.4797, subdivision 3, is amended to read:

Subd. 3. **Supervision of staff providing delegated nursing or therapy home care tasks.** (a) Staff who perform delegated nursing or therapy home care tasks must be supervised by an appropriate licensed health professional or a registered nurse periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the client.

(b) The direct supervision of staff performing delegated tasks must be provided within 30 days after the date on which the individual begins working for the home care provider and first performs delegated tasks for clients and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.

Sec. 60. Minnesota Statutes 2018, section 144A.4798, is amended to read:

**144A.4798 ~~EMPLOYEE HEALTH STATUS~~ DISEASE PREVENTION AND INFECTION CONTROL.**

Subdivision 1. **Tuberculosis (TB) ~~prevention and~~ infection control.** (a) A home care provider must establish and maintain a ~~TB prevention and~~ comprehensive tuberculosis

infection control program ~~based on~~ according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. ~~Components of a TB prevention and control program include screening all staff providing home care services, both paid and unpaid, at the time of hire for active TB disease and latent TB infection, and developing and implementing a written TB infection control plan. The commissioner shall make the most recent CDC standards available to home care providers on the department's website.~~ This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.

(b) The home care provider must maintain written evidence of compliance with this subdivision.

Subd. 2. **Communicable diseases.** A home care provider must follow current ~~federal or state guidelines~~ state requirements for prevention, control, and reporting of ~~human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus, or other~~ communicable diseases as defined in Minnesota Rules, ~~part~~ parts 4605.7040, 4605.7044, 4605.7050, 4605.7075, 4605.7080, and 4605.7090.

Subd. 3. **Infection control program.** A home care provider must establish and maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control.

Sec. 61. Minnesota Statutes 2018, section 144A.4799, subdivision 1, is amended to read:

Subdivision 1. **Membership.** The commissioner of health shall appoint eight persons to a home care and assisted living program advisory council consisting of the following:

(1) three public members as defined in section 214.02 who shall be ~~either~~ persons who are currently receiving home care services ~~or~~, persons who have received home care services within five years of the application date, persons who have family members receiving home care services, or persons who have family members who have received home care services within five years of the application date;

(2) three Minnesota home care licensees representing basic and comprehensive levels of licensure who may be a managerial official, an administrator, a supervising registered nurse, or an unlicensed personnel performing home care tasks;

(3) one member representing the Minnesota Board of Nursing; and

(4) one member representing the Office of Ombudsman for Long-Term Care.

Sec. 62. Minnesota Statutes 2018, section 144A.4799, subdivision 3, is amended to read:

Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide advice regarding regulations of Department of Health licensed home care providers in this chapter, including advice on the following:

(1) community standards for home care practices;

(2) enforcement of licensing standards and whether certain disciplinary actions are appropriate;

(3) ways of distributing information to licensees and consumers of home care;

(4) training standards;

(5) identifying emerging issues and opportunities in ~~the~~ home care ~~field, including~~ and assisted living;

(6) identifying the use of technology in home and telehealth capabilities;

~~(6)~~ (7) allowable home care licensing modifications and exemptions, including a method for an integrated license with an existing license for rural licensed nursing homes to provide limited home care services in an adjacent independent living apartment building owned by the licensed nursing home; and

~~(7)~~ (8) recommendations for studies using the data in section 62U.04, subdivision 4, including but not limited to studies concerning costs related to dementia and chronic disease among an elderly population over 60 and additional long-term care costs, as described in section 62U.10, subdivision 6.

(b) The advisory council shall perform other duties as directed by the commissioner.

(c) The advisory council shall annually review the balance of the account in the state government special revenue fund described in section 144A.474, subdivision 11, paragraph (i), and make annual recommendations by January 15 directly to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services regarding appropriations to the commissioner for the purposes in section 144A.474, subdivision 11, paragraph (i).

Sec. 63. Minnesota Statutes 2018, section 144A.484, subdivision 1, is amended to read:

Subdivision 1. **Integrated licensing established.** ~~(a) From January 1, 2014, to June 30, 2015, the commissioner of health shall enforce the home and community-based services standards under chapter 245D for those providers who also have a home care license pursuant to this chapter as required under Laws 2013, chapter 108, article 8, section 60, and article 11, section 31. During this period, the commissioner shall provide technical assistance to achieve and maintain compliance with applicable law or rules governing the provision of home and community-based services, including complying with the service recipient rights notice in subdivision 4, clause (4). If during the survey, the commissioner finds that the licensee has failed to achieve compliance with an applicable law or rule under chapter 245D and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the commissioner may issue a licensing survey report with recommendations for achieving and maintaining compliance.~~

~~(b) Beginning July 1, 2015,~~ A home care provider applicant or license holder may apply to the commissioner of health for a home and community-based services designation for the provision of basic support services identified under section 245D.03, subdivision 1, paragraph (b). The designation allows the license holder to provide basic support services that would otherwise require licensure under chapter 245D, under the license holder's home care license governed by sections 144A.43 to ~~144A.481~~ 144A.4799.

Sec. 64. Minnesota Statutes 2018, section 145.4235, subdivision 2, is amended to read:

Subd. 2. **Eligibility for grants.** (a) The commissioner shall award grants to eligible applicants under paragraph (c) for the reasonable expenses of alternatives to abortion programs to support, encourage, and assist women in carrying their pregnancies to term and caring for their babies after birth by providing information on, referral to, and assistance with securing necessary services that enable women to carry their pregnancies to term and care for their babies after birth. Necessary services must include, but are not limited to:

(1) medical care;

(2) nutritional services;

(3) housing assistance;

(4) adoption services;

(5) education and employment assistance, including services that support the continuation and completion of high school;

(6) child care assistance; and

(7) parenting education and support services.

An applicant may not provide or assist a woman to obtain adoption services from a provider of adoption services that is not licensed.

(b) In addition to providing information and referral under paragraph (a), an eligible program may provide one or more of the necessary services under paragraph (a) that assists women in carrying their pregnancies to term. To avoid duplication of efforts, grantees may refer to other public or private programs, rather than provide the care directly, if a woman meets eligibility criteria for the other programs.

(c) To be eligible for a grant, an agency or organization must:

(1) be a private, nonprofit organization;

(2) demonstrate that the program is conducted under appropriate supervision;

(3) not charge women for services provided under the program;

(4) provide each pregnant woman counseled with accurate information on the developmental characteristics of babies and of unborn children, including offering the printed information described in section 145.4243;

(5) ensure that its alternatives-to-abortion program's purpose is to assist and encourage women in carrying their pregnancies to term and to maximize their potentials thereafter;

(6) ensure that none of the money provided is used to encourage or affirmatively counsel a woman to have an abortion not necessary to prevent her death, to provide her an abortion, or to directly refer her to an abortion provider for an abortion. The agency or organization may provide nondirective counseling; and

(7) have had the alternatives to abortion program in existence for at least one year as of July 1, 2011; or incorporated an alternative to abortion program that has been in existence for at least one year as of July 1, 2011.

(d) The provisions, words, phrases, and clauses of paragraph (c) are inseverable from this subdivision, and if any provision, word, phrase, or clause of paragraph (c) or its application to any person or circumstance is held invalid, the invalidity applies to all of this subdivision.

(e) An organization that provides abortions, promotes abortions, or directly refers to an abortion provider for an abortion is ineligible to receive a grant under this program. An affiliate of an organization that provides abortions, promotes abortions, or directly refers

to an abortion provider for an abortion is ineligible to receive a grant under this section unless the organizations are separately incorporated and independent from each other. To be independent, the organizations may not share any of the following:

(1) the same or a similar name;

(2) medical facilities or nonmedical facilities, including but not limited to, business offices, treatment rooms, consultation rooms, examination rooms, and waiting rooms;

(3) expenses;

(4) employee wages or salaries; or

(5) equipment or supplies, including but not limited to, computers, telephone systems, telecommunications equipment, and office supplies.

(f) An organization that receives a grant under this section and that is affiliated with an organization that provides abortion services must maintain financial records that demonstrate strict compliance with this subdivision and that demonstrate that its independent affiliate that provides abortion services receives no direct or indirect economic or marketing benefit from the grant under this section.

(g) An organization that receives a grant under this section must, in its name, signage, and printed materials, clearly convey to the public and to pregnant women seeking services that the purpose of the organization is to support, encourage, and assist women in carrying their pregnancies to term and caring for their babies after birth, and that the organization does not provide counseling for abortion services or referrals for abortion services.

(h) All written materials provided by a grantee must be medically accurate. The commissioner shall approve any written information provided by a grantee ~~on the health risks associated with abortions~~ to ensure that the information is medically accurate. For purposes of this subdivision, "medically accurate" means information that is:

(1) verified or supported by the weight of peer-reviewed medical research conducted in compliance with accepted scientific methods;

(2) recognized as medically sound and objective by:

(i) leading health care organizations with relevant expertise, such as the American Medical Association, the American Congress of Obstetricians and Gynecologists, the American Public Health Association, the American Psychological Association, the American Academy of Pediatrics, the American College of Physicians, and the American Academy of Family Physicians;

(ii) federal agencies such as the Centers for Disease Control and Prevention, the Food and Drug Administration, the National Cancer Institute, and the National Institutes of Health; or

(iii) leading national or international scientific advisory groups such as the Health and Medicine Division and the Advisory Committee on Immunization Practices; or

(3) recommended by or affirmed in the health care practice guidelines of a nationally recognized health care accreditation organization.

Sec. 65. Minnesota Statutes 2018, section 145.4235, subdivision 3, is amended to read:

Subd. 3. **Privacy protection.** (a) Any program receiving a grant under this section must have a privacy policy and procedures in place to ensure that the name, address, telephone number, or any other information that might identify any woman seeking the services of the program is not made public or shared with any other agency or organization without the written consent of the woman. A disclosure of individually identifiable information under this subdivision shall be limited to disclosures expressly permitted in the woman's written consent. All communications between the program and the woman must remain confidential. For purposes of any medical care provided by the program, including, but not limited to, pregnancy tests or ultrasonic scanning, the program must adhere to the requirements in sections 144.291 to 144.298 that apply to providers before releasing any information relating to the medical care provided.

(b) Notwithstanding paragraph (a), the commissioner has access to any information necessary to monitor and review a grantee's program as required under subdivision 4.

(c) Notwithstanding section 144.292, subdivisions 5 and 6, a program receiving a grant under this section must, at the request of a woman who received services from the program:

(1) if the program holds the woman's health record, make the health record held by the program available to the woman for examination and copying at the program site during the program's regular business hours, or provide the woman with a copy of the health record. The program must provide the woman with the opportunity to copy the woman's health record on site, or a copy of the woman's health record, at no cost to the woman, and must provide the copy or opportunity to copy promptly but no later than 15 working days after her request; or

(2) if the program does not hold the woman's health record, inform the woman that the health record does not exist or cannot be found or that the health record is held by another entity. If the program can identify the entity that currently holds the woman's health record,

the program must provide the woman with the name and contact information of that entity. This information must be provided promptly after the woman's request.

Sec. 66. Minnesota Statutes 2018, section 145.4235, is amended by adding a subdivision to read:

Subd. 3a. **Provision of pregnancy test results.** A program receiving a grant under this section that provides or assists in the provision of pregnancy tests shall provide a woman who undergoes a pregnancy test with a written statement of the pregnancy test results, at no cost to the woman. This written statement must be provided in the language requested by the woman and must be provided to the woman immediately after the test results are available.

Sec. 67. Minnesota Statutes 2018, section 145.4235, subdivision 4, is amended to read:

Subd. 4. **Duties of commissioner.** The commissioner shall make grants under subdivision 2 beginning no later than July 1, 2006. In awarding grants, the commissioner shall consider the program's demonstrated capacity in providing services to assist a pregnant woman in carrying her pregnancy to term. The commissioner shall monitor and review the programs of each grantee to ensure that the grantee carefully adheres to the purposes and requirements of subdivision 2 and shall cease funding a grantee that fails to do so. The commissioner shall also establish an evaluation process for grants awarded under this section, shall use this evaluation process to evaluate programs receiving grants each grant cycle, and shall use the evaluation results to inform grant award decisions for subsequent grant cycles.

Sec. 68. **[145.87] HOME VISITING FOR PREGNANT WOMEN AND FAMILIES WITH YOUNG CHILDREN.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Evidence-based home visiting program" means a program that:

(1) is based on a clear, consistent program or model that is research-based and grounded in relevant, empirically based knowledge;

(2) is linked to program-determined outcomes and is associated with a national organization, institution of higher education, or national or state public health institute;

(3) has comprehensive home visitation standards that ensure high-quality service delivery and continuous quality improvement;

(4) has demonstrated significant, sustained positive outcomes; and

(5) either (i) has been evaluated using rigorous, randomized controlled research designs with the evaluations published in a peer-reviewed journal; or (ii) is based on quasi-experimental research using two or more separate, comparable client samples.

(c) "Evidence-informed home visiting program" means a program that:

(1) has data or evidence demonstrating the program's effectiveness at achieving positive outcomes for pregnant women and young children; and

(2) either has (i) an active evaluation of the program; or (ii) a plan and timeline for an active evaluation of the program to be conducted.

(d) "Health equity" means every individual has a fair opportunity to attain the individual's full health potential, and no individual is prevented from achieving this potential.

Subd. 2. **Grants for home visiting programs.** The commissioner shall award grants to community health boards, nonprofit organizations, and tribal nations to start up or expand home visiting programs serving pregnant women and families with young children. Home visiting programs supported under this section shall provide home visits by early childhood professionals or health professionals, including nurses, social workers, early childhood educators, or trained paraprofessionals. Grant funds shall be used:

(1) to start up or expand evidence-based home visiting programs that address health equity, or evidence-informed home visiting programs that address health equity; and

(2) to serve families with young children or pregnant women who are high risk or have high needs. For purposes of this clause, high risk includes but is not limited to a family with low income, or a parent or pregnant woman with mental illness or a substance use disorder or experiencing domestic abuse.

Subd. 3. **Grant prioritization.** (a) In awarding grants, the commissioner shall give priority to community health boards, nonprofit organizations, and tribal nations seeking to expand home visiting services with community or regional partnerships.

(b) The commissioner shall allocate at least 75 percent of the grant funds awarded each grant cycle to evidence-based home visiting programs that address health equity and up to 25 percent of the grant funds awarded each grant cycle to evidence-informed home visiting programs that address health equity.

Subd. 4. **No supplanting of existing funds.** Funding awarded under this section shall only be used to supplement, and not to replace, funds being used for evidence-based home visiting programs or evidence-informed home visiting programs.

Subd. 5. **Administrative costs.** The commissioner may use up to ten percent of the annual appropriation under this section to provide training and technical assistance and to administer and evaluate the program. The commissioner may contract for training, capacity-building support for grantees or potential grantees, technical assistance, and evaluation support.

Sec. 69. **[145.9275] COMMUNITY-BASED OPIOID PREVENTION; PILOT GRANT PROGRAM.**

To the extent funds are appropriated for the purposes of this section, the commissioner shall establish a grant program to fund community opioid abuse prevention pilot grants to reduce emergency room and other health care provider visits resulting from opioid use or abuse and to reduce rates of opioid addiction in the community using the following six activities:

(1) establishing multidisciplinary controlled substance care teams that may consist of physicians, pharmacists, social workers, nurse care coordinators, advanced practice registered nurses, and mental health professionals;

(2) delivering health care services and care coordination, through controlled substance care teams, to reduce the inappropriate use of opioids by patients and rates of opioid addiction;

(3) addressing any unmet social services needs that create barriers to managing pain effectively and obtaining optimal health outcomes;

(4) providing prescriber and dispenser education and assistance to reduce the inappropriate prescribing and dispensing of opioids;

(5) promoting the adoption of best practices related to opioid disposal and reducing opportunities for illegal access to opioids; and

(6) engaging partners outside of the health care system, including schools, law enforcement, and social services, to address root causes of opioid abuse and addiction at the community level.

Sec. 70. **[145.9285] COMMUNITY SOLUTIONS FOR HEALTHY CHILD DEVELOPMENT GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner shall establish the community solutions for healthy child development grant program. The purposes of the program are to:

(1) improve child development outcomes as related to the well-being of children of color and American Indian children from prenatal to grade 3 and their families, including but not limited to the goals outlined by the Department of Human Service's early childhood systems reform effort: early learning; health and well-being; economic security; and safe, stable, nurturing relationships and environments by funding community-based solutions for challenges that are identified by the affected community;

(2) reduce racial disparities in children's health and development, from prenatal to grade 3; and

(3) promote racial and geographic equity.

Subd. 2. **Commissioner's duties.** The commissioner of health shall:

(1) develop a request for proposals for the healthy child development grant program in consultation with the Community Solutions Advisory Council;

(2) provide outreach, technical assistance, and program development support to increase capacity for new and existing service providers in order to better meet statewide needs, particularly in greater Minnesota and areas where services to reduce health disparities have not been established;

(3) review responses to requests for proposals, in consultation with the Community Solutions Advisory Council, and award grants under this section;

(4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council, and the governor's early learning council on the request for proposal process;

(5) establish a transparent and objective accountability process, in consultation with the Community Solutions Advisory Council, focused on outcomes that grantees agree to achieve;

(6) provide grantees with access to data to assist grantees in establishing and implementing effective community-led solutions;

(7) maintain data on outcomes reported by grantees; and

(8) contract with an independent third-party entity to evaluate the success of the grant program and to build the evidence base for effective community solutions in reducing health disparities of children of color and American Indian children from prenatal to grade 3.

Subd. 3. **Community Solutions Advisory Council; establishment; duties; compensation.** (a) No later than October 1, 2019, the commissioner shall convene a 12-member Community Solutions Advisory Council as follows:

(1) two members representing the African Heritage community;

(2) two members representing the Latino community;

(3) two members representing the Asian-Pacific Islander community;

(4) two members representing the American Indian community;

(5) two parents of children of color or that are American Indian with children under nine years of age;

(6) one member with research or academic expertise in racial equity and healthy child development; and

(7) one member representing an organization that advocates on behalf of communities of color or American Indians.

(b) At least three of the 12 members of the advisory council must come from outside the seven-county metropolitan area.

(c) The Community Solutions Advisory Council shall:

(1) advise the commissioner on the development of the request for proposals for community solutions healthy child development grants. In advising the commissioner, the council must consider how to build on the capacity of communities to promote child and family well-being and address social determinants of healthy child development;

(2) review responses to requests for proposals and advise the commissioner on the selection of grantees and grant awards;

(3) advise the commissioner on the establishment of a transparent and objective accountability process focused on outcomes the grantees agree to achieve;

(4) advise the commissioner on ongoing oversight and necessary support in the implementation of the program; and

(5) support the commissioner on other racial equity and early childhood grant efforts.

(d) Each advisory council member shall be compensated in accordance with section 15.059, subdivision 3.

Subd. 4. **Eligible grantees.** Organizations eligible to receive grant funding under this section include:

(1) organizations or entities that work with communities of color and American Indian communities;

(2) tribal nations and tribal organizations as defined in section 658P of the Child Care and Development Block Grant Act of 1990; and

(3) organizations or entities focused on supporting healthy child development.

Subd. 5. **Strategic consideration and priority of proposals; eligible populations; grant awards.** (a) The commissioner, in consultation with the Community Solutions Advisory Council, shall develop a request for proposals for healthy child development grants. In developing the proposals and awarding the grants, the commissioner shall consider building on the capacity of communities to promote child and family well-being and address social determinants of healthy child development. Proposals must focus on increasing racial equity and healthy child development and reducing health disparities experienced by children of color and American Indian children from prenatal to grade 3 and their families.

(b) In awarding the grants, the commissioner shall provide strategic consideration and give priority to proposals from:

(1) organizations or entities led by people of color and serving communities of color;

(2) organizations or entities led by American Indians and serving American Indians, including tribal nations and tribal organizations;

(3) organizations or entities with proposals focused on healthy development from prenatal to age three;

(4) organizations or entities with proposals focusing on multigenerational solutions;

(5) organizations or entities located in or with proposals to serve communities located in counties that are moderate to high risk according to the Wilder Research Risk and Reach Report; and

(6) community-based organizations that have historically served communities of color and American Indians and have not traditionally had access to state grant funding.

The advisory council may recommend additional strategic considerations and priorities to the commissioner.

(c) The first round of grants must be awarded no later than April 15, 2020.

Subd. 6. **Geographic distribution of grants.** The commissioner and the advisory council shall ensure that grant funds are prioritized and awarded to organizations and entities that are within counties that have a higher proportion of people of color and American Indians than the state average, to the extent possible.

Subd. 7. **Report.** Grantees must report grant program outcomes to the commissioner on the forms and according to the timelines established by the commissioner.

Sec. 71. **[145.987] DOMESTIC VIOLENCE AND SEXUAL ASSAULT PREVENTION PROGRAM.**

Subdivision 1. **Program establishment.** The commissioner of health shall administer the domestic violence and sexual assault prevention program as established under this section.

Subd. 2. **Grant criteria.** (a) The commissioner shall award grants to nonprofit organizations for the purpose of funding programs that incorporate community-driven and culturally relevant practices to prevent domestic violence and sexual assault. Grants made pursuant to this section may either (1) encourage the development and deployment of new prevention efforts, or (2) enhance, sustain, or expand existing prevention efforts.

(b) The commissioner of health shall award grants to nonprofit organizations supporting activities that:

(1) promote the general development of domestic violence and sexual assault prevention programs and activities;

(2) implement prevention activities through community outreach that address the root causes of domestic violence and sexual assault;

(3) identify risk and protective factors for developing domestic violence and sexual assault prevention strategies and outreach activities;

(4) provide trauma-informed domestic violence and sexual assault prevention services;

(5) educate youth and adults about healthy relationships and changing social norms;

(6) develop culturally and linguistically appropriate domestic violence and sexual assault prevention programs for historically underserved communities;

(7) work collaboratively with educational institutions, including school districts, to implement domestic violence and sexual assault prevention strategies for students, teachers, and administrators; or

(8) work collaboratively with other nonprofit organizations, for-profit organizations, and other community-based organizations to implement domestic violence and sexual assault prevention strategies within their communities.

Subd. 3. **Definition.** For purposes of this section, "domestic violence and sexual assault" includes, but is not limited to, the following:

(1) intimate partner violence, including emotional, psychological, and economic abuse;

(2) sex trafficking as defined in section 609.321, subdivision 7a;

(3) domestic abuse as defined in section 518B.01, subdivision 2;

(4) any criminal sexual conduct crime in sections 609.342 to 609.3453;

(5) abusive international marriage;

(6) forced marriage; and

(7) female genital mutilation, as defined in section 609.2245, subdivision 1.

Subd. 4. **Promotion; administration.** The commissioner may spend up to 15 percent of the total program funding for each fiscal year to promote and administer the program authorized under this section and to provide technical assistance to program grantees.

Subd. 5. **Nonstate sources.** The commissioner may accept contributions from nonstate sources to supplement state appropriations for the program authorized under this section. Contributions received under this subdivision are appropriated to the commissioner for purposes of this section.

Subd. 6. **Program evaluation.** (a) The commissioner of health shall report by February 28 of each even-numbered year to the legislative committees with jurisdiction over health detailing the expenditures of funds authorized under this section. The commissioner shall use the data to evaluate the effectiveness of the program. The commissioner must include in the report:

(1) the number of organizations receiving grant money under this section;

(2) the number of individuals served by the grant program;

(3) a description and analysis of the practices implemented by program grantees; and

(4) best practices recommendations to prevent domestic violence and sexual assault, including best practices recommendations that are culturally relevant to historically underserved communities.

(b) Any organization receiving grant money under this section must collect and make available to the commissioner of health aggregate data related to the activity funded by the grant program under this section.

(c) The commissioner of health shall use the information and data from the program evaluation under paragraph (a), including best practices and culturally specific responses, to inform the administration of existing Department of Health programming and the development of Department of Health policies, programs, and procedures.

Sec. 72. Minnesota Statutes 2018, section 152.22, is amended by adding a subdivision to read:

Subd. 5a. **Hemp.** "Hemp" has the meaning given to industrial hemp in section 18K.02, subdivision 3. Hemp is not marijuana as defined in section 152.01, subdivision 9.

Sec. 73. Minnesota Statutes 2018, section 152.22, is amended by adding a subdivision to read:

Subd. 5b. **Hemp grower.** "Hemp grower" means a person licensed by the commissioner of agriculture under chapter 18K to grow hemp for commercial purposes.

Sec. 74. Minnesota Statutes 2018, section 152.22, subdivision 6, is amended to read:

Subd. 6. **Medical cannabis.** (a) "Medical cannabis" means any species of the genus cannabis plant, or any mixture or preparation of them, including whole plant extracts and resins, and is delivered in the form of:

(1) liquid, including, but not limited to, oil;

(2) pill;

(3) vaporized delivery method with use of liquid ~~or~~, oil ~~but which does not require the use of dried leaves or plant form~~, or raw cannabis; or

(4) any other method, excluding smoking, approved by the commissioner.

(b) This definition includes any part of the genus cannabis plant prior to being processed into a form allowed under paragraph (a), that is possessed by a person while that person is engaged in employment duties necessary to carry out a requirement under sections 152.22 to 152.37 for a registered manufacturer or a laboratory under contract with a registered manufacturer.

Sec. 75. Minnesota Statutes 2018, section 152.22, subdivision 11, is amended to read:

Subd. 11. **Registered designated caregiver.** "Registered designated caregiver" means a person who:

(1) is at least ~~21~~ 18 years old;

(2) does not have a conviction for a disqualifying felony offense;

(3) has been approved by the commissioner to assist a patient who has been identified by a health care practitioner as developmentally or physically disabled and therefore ~~unable~~

~~to self-administer medication~~ requires assistance in administering medical cannabis or ~~acquire~~ obtaining medical cannabis from a distribution facility due to the disability; and

(4) is authorized by the commissioner to assist the patient with the use of medical cannabis.

Sec. 76. Minnesota Statutes 2018, section 152.22, subdivision 13, is amended to read:

Subd. 13. **Registry verification.** "Registry verification" means the verification provided by the commissioner that a patient is enrolled in the registry program and that includes the patient's name, registry number, ~~and qualifying medical condition~~ and, if applicable, the name of the patient's registered designated caregiver or parent ~~or~~, legal guardian, or spouse.

Sec. 77. Minnesota Statutes 2018, section 152.22, subdivision 14, is amended to read:

Subd. 14. **Qualifying medical condition.** "Qualifying medical condition" means a diagnosis of any of the following conditions:

(1) cancer~~, if the underlying condition or treatment produces one or more of the following:~~;

~~(i) severe or chronic pain;~~

~~(ii) nausea or severe vomiting; or~~

~~(iii) cachexia or severe wasting;~~

(2) glaucoma;

(3) human immunodeficiency virus or acquired immune deficiency syndrome;

(4) Tourette's syndrome;

(5) amyotrophic lateral sclerosis;

(6) seizures, including those characteristic of epilepsy;

(7) severe and persistent muscle spasms, including those characteristic of multiple sclerosis;

(8) inflammatory bowel disease, including Crohn's disease;

(9) terminal illness~~, with a probable life expectancy of under one year, if the illness or its treatment produces one or more of the following:~~;

~~(i) severe or chronic pain;~~

~~(ii) nausea or severe vomiting; or~~

~~(iii) cachexia or severe wasting; or~~

(10) any chronic condition for which an opiate could otherwise be prescribed;

(11) chronic pain or intractable pain; or

~~(10)~~ (12) any other medical condition or its treatment approved by the commissioner.

Sec. 78. Minnesota Statutes 2018, section 152.25, subdivision 1, is amended to read:

Subdivision 1. **Medical cannabis manufacturer registration.** (a) The commissioner shall register two in-state manufacturers for the production of all medical cannabis within the state. A registration agreement between the commissioner and a manufacturer is nontransferable. The commissioner shall register new manufacturers or reregister the existing manufacturers by December 1 every two years, using the factors described in this subdivision. The commissioner shall accept applications after December 1, 2014, if one of the manufacturers registered before December 1, 2014, ceases to be registered as a manufacturer. The commissioner's determination that no manufacturer exists to fulfill the duties under sections 152.22 to 152.37 is subject to judicial review in Ramsey County District Court. Data submitted during the application process are private data on individuals or nonpublic data as defined in section 13.02 until the manufacturer is registered under this section. Data on a manufacturer that is registered are public data, unless the data are trade secret or security information under section 13.37.

(b) As a condition for registration, a manufacturer must agree to:

(1) begin supplying medical cannabis to patients by July 1, 2015; and

(2) comply with all requirements under sections 152.22 to 152.37.

(c) The commissioner shall consider the following factors when determining which manufacturer to register:

(1) the technical expertise of the manufacturer in cultivating medical cannabis and converting the medical cannabis into an acceptable delivery method under section 152.22, subdivision 6;

(2) the qualifications of the manufacturer's employees;

(3) the long-term financial stability of the manufacturer;

(4) the ability to provide appropriate security measures on the premises of the manufacturer;

(5) whether the manufacturer has demonstrated an ability to meet the medical cannabis production needs required by sections 152.22 to 152.37; and

(6) the manufacturer's projection and ongoing assessment of fees on patients with a qualifying medical condition.

(d) If an officer, director, or controlling person of the manufacturer pleads or is found guilty of intentionally diverting medical cannabis to a person other than allowed by law under section 152.33, subdivision 1, the commissioner may decide not to renew the registration of the manufacturer, provided the violation occurred while the person was an officer, director, or controlling person of the manufacturer.

(e) The commissioner shall require each medical cannabis manufacturer to contract with an independent laboratory to test medical cannabis produced by the manufacturer. The commissioner shall approve the laboratory chosen by each manufacturer and require that the laboratory report testing results to the manufacturer in a manner determined by the commissioner.

Sec. 79. Minnesota Statutes 2018, section 152.25, subdivision 1a, is amended to read:

Subd. 1a. **Revocation~~,~~ or nonrenewal~~, or denial of consent to transfer~~ of a medical cannabis manufacturer registration.** If the commissioner intends to revoke~~,~~ or not renew~~, or deny consent to transfer~~ a registration issued under this section, the commissioner must first notify in writing the manufacturer against whom the action is to be taken and provide the manufacturer with an opportunity to request a hearing under the contested case provisions of chapter 14. If the manufacturer does not request a hearing by notifying the commissioner in writing within 20 days after receipt of the notice of proposed action, the commissioner may proceed with the action without a hearing. For revocations, the registration of a manufacturer is considered revoked on the date specified in the commissioner's written notice of revocation.

Sec. 80. Minnesota Statutes 2018, section 152.25, subdivision 1c, is amended to read:

Subd. 1c. **Notice to patients.** Upon the revocation or nonrenewal of a manufacturer's registration under subdivision 1a or implementation of an enforcement action under subdivision 1b that may affect the ability of a registered patient, registered designated caregiver, or a registered patient's parent ~~or~~, legal guardian, or spouse to obtain medical cannabis from the manufacturer subject to the enforcement action, the commissioner shall notify in writing each registered patient and the patient's registered designated caregiver or registered patient's parent ~~or~~, legal guardian, or spouse about the outcome of the proceeding

and information regarding alternative registered manufacturers. This notice must be provided two or more business days prior to the effective date of the revocation, nonrenewal, or other enforcement action.

Sec. 81. Minnesota Statutes 2018, section 152.25, subdivision 4, is amended to read:

Subd. 4. **Reports.** (a) The commissioner shall provide regular updates to the task force on medical cannabis therapeutic research and to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services, public safety, judiciary, and civil law regarding: (1) any changes in federal law or regulatory restrictions regarding the use of medical cannabis or hemp; and (2) the market demand and supply in this state for products made from hemp that can be used for medicinal purposes.

(b) The commissioner may submit medical research based on the data collected under sections 152.22 to 152.37 to any federal agency with regulatory or enforcement authority over medical cannabis to demonstrate the effectiveness of medical cannabis for treating a qualifying medical condition.

Sec. 82. Minnesota Statutes 2018, section 152.27, subdivision 2, is amended to read:

Subd. 2. **Commissioner duties.** (a) The commissioner shall:

(1) give notice of the program to health care practitioners in the state who are eligible to serve as health care practitioners and explain the purposes and requirements of the program;

(2) allow each health care practitioner who meets or agrees to meet the program's requirements and who requests to participate, to be included in the registry program to collect data for the patient registry;

(3) provide explanatory information and assistance to each health care practitioner in understanding the nature of therapeutic use of medical cannabis within program requirements;

(4) create and provide a certification to be used by a health care practitioner for the practitioner to certify whether a patient has been diagnosed with a qualifying medical condition and include in the certification an option for the practitioner to certify whether the patient, in the health care practitioner's medical opinion, is developmentally or physically disabled and, as a result of that disability, the patient ~~is unable to self-administer medication~~ requires assistance in administering medical cannabis or ~~acquire~~ obtaining medical cannabis from a distribution facility;

(5) supervise the participation of the health care practitioner in conducting patient treatment and health records reporting in a manner that ensures stringent security and record-keeping requirements and that prevents the unauthorized release of private data on individuals as defined by section 13.02;

(6) develop safety criteria for patients with a qualifying medical condition as a requirement of the patient's participation in the program, to prevent the patient from undertaking any task under the influence of medical cannabis that would constitute negligence or professional malpractice on the part of the patient; and

(7) conduct research and studies based on data from health records submitted to the registry program and submit reports on intermediate or final research results to the legislature and major scientific journals. The commissioner may contract with a third party to complete the requirements of this clause. Any reports submitted must comply with section 152.28, subdivision 2.

(b) If the commissioner wishes to add a delivery method under section 152.22, subdivision 6, or a qualifying medical condition under section 152.22, subdivision 14, the commissioner must notify the chairs and ranking minority members of the legislative policy committees having jurisdiction over health and public safety of the addition and the reasons for its addition, including any written comments received by the commissioner from the public and any guidance received from the task force on medical cannabis research, by January 15 of the year in which the commissioner wishes to make the change. The change shall be effective on August 1 of that year, unless the legislature by law provides otherwise.

Sec. 83. Minnesota Statutes 2018, section 152.27, subdivision 3, is amended to read:

Subd. 3. **Patient application.** (a) The commissioner shall develop a patient application for enrollment into the registry program. The application shall be available to the patient and given to health care practitioners in the state who are eligible to serve as health care practitioners. The application must include:

(1) the name, mailing address, and date of birth of the patient;

(2) the name, mailing address, and telephone number of the patient's health care practitioner;

(3) the name, mailing address, and date of birth of the patient's designated caregiver, if any, or the patient's parent ~~or~~, legal guardian, or spouse if the parent ~~or~~, legal guardian, or spouse will be acting as a caregiver;

(4) a copy of the certification from the patient's health care practitioner that is dated within 90 days prior to submitting the application which certifies that the patient has been diagnosed with a qualifying medical condition and, if applicable, that, in the health care practitioner's medical opinion, the patient is developmentally or physically disabled and, as a result of that disability, the patient ~~is unable to self-administer medication~~ requires assistance in administering medical cannabis or ~~acquire~~ obtaining medical cannabis from a distribution facility; and

(5) all other signed affidavits and enrollment forms required by the commissioner under sections 152.22 to 152.37, including, but not limited to, the disclosure form required under paragraph (c).

(b) The commissioner shall require a patient to resubmit a copy of the certification from the patient's health care practitioner on a yearly basis and shall require that the recertification be dated within 90 days of submission.

(c) The commissioner shall develop a disclosure form and require, as a condition of enrollment, all patients to sign a copy of the disclosure. The disclosure must include:

(1) a statement that, notwithstanding any law to the contrary, the commissioner, or an employee of any state agency, may not be held civilly or criminally liable for any injury, loss of property, personal injury, or death caused by any act or omission while acting within the scope of office or employment under sections 152.22 to 152.37; and

(2) the patient's ~~acknowledgement~~ acknowledgment that enrollment in the patient registry program is conditional on the patient's agreement to meet all of the requirements of sections 152.22 to 152.37.

Sec. 84. Minnesota Statutes 2018, section 152.27, subdivision 4, is amended to read:

Subd. 4. **Registered designated caregiver.** (a) The commissioner shall register a designated caregiver for a patient if the patient's health care practitioner has certified that the patient, in the health care practitioner's medical opinion, is developmentally or physically disabled and, as a result of that disability, the patient ~~is unable to self-administer medication or acquire~~ requires assistance in administering medical cannabis or obtaining medical cannabis from a distribution facility and the caregiver has agreed, in writing, to be the patient's designated caregiver. As a condition of registration as a designated caregiver, the commissioner shall require the person to:

(1) be at least ~~21~~ 18 years of age;

(2) agree to only possess ~~any~~ the patient's medical cannabis for purposes of assisting the patient; and

(3) agree that if the application is approved, the person will not be a registered designated caregiver for more than one patient, unless the patients reside in the same residence.

(b) The commissioner shall conduct a criminal background check on the designated caregiver prior to registration to ensure that the person does not have a conviction for a disqualifying felony offense. Any cost of the background check shall be paid by the person seeking registration as a designated caregiver. A designated caregiver must have the criminal background check renewed every two years.

(c) Nothing in sections 152.22 to 152.37 shall be construed to prevent a person registered as a designated caregiver from also being enrolled in the registry program as a patient and possessing and using medical cannabis as a patient.

Sec. 85. Minnesota Statutes 2018, section 152.27, subdivision 5, is amended to read:

Subd. 5. **Parents ~~or~~, legal guardians, and spouses.** A parent ~~or~~, legal guardian, or spouse of a patient may act as the caregiver to the patient without having to register as a designated caregiver. The parent ~~or~~, legal guardian, or spouse shall follow all of the requirements of parents ~~and~~, legal guardians, and spouses listed in sections 152.22 to 152.37. Nothing in sections 152.22 to 152.37 limits any legal authority a parent ~~or~~, legal guardian, or spouse may have for the patient under any other law.

Sec. 86. Minnesota Statutes 2018, section 152.27, subdivision 6, is amended to read:

Subd. 6. **Patient enrollment.** (a) After receipt of a patient's application, application fees, and signed disclosure, the commissioner shall enroll the patient in the registry program and issue the patient and patient's registered designated caregiver or parent ~~or~~, legal guardian, or spouse, if applicable, a registry verification. The commissioner shall approve or deny a patient's application for participation in the registry program within 30 days after the commissioner receives the patient's application and application fee. The commissioner may approve applications up to 60 days after the receipt of a patient's application and application fees until January 1, 2016. A patient's enrollment in the registry program shall only be denied if the patient:

(1) does not have certification from a health care practitioner that the patient has been diagnosed with a qualifying medical condition;

(2) has not signed and returned the disclosure form required under subdivision 3, paragraph (c), to the commissioner;

(3) does not provide the information required;

(4) has previously been removed from the registry program for violations of section 152.30 or 152.33; or

(5) provides false information.

(b) The commissioner shall give written notice to a patient of the reason for denying enrollment in the registry program.

(c) Denial of enrollment into the registry program is considered a final decision of the commissioner and is subject to judicial review under the Administrative Procedure Act pursuant to chapter 14.

(d) A patient's enrollment in the registry program may only be revoked upon the death of the patient or if a patient violates a requirement under section 152.30 or 152.33.

(e) The commissioner shall develop a registry verification to provide to the patient, the health care practitioner identified in the patient's application, and to the manufacturer. The registry verification shall include:

(1) the patient's name and date of birth;

(2) the patient registry number assigned to the patient; and

~~(3) the patient's qualifying medical condition as provided by the patient's health care practitioner in the certification; and~~

~~(4)~~ (3) the name and date of birth of the patient's registered designated caregiver, if any, or the name of the patient's parent ~~or~~, legal guardian, or spouse if the parent ~~or~~, legal guardian, or spouse will be acting as a caregiver.

Sec. 87. Minnesota Statutes 2018, section 152.28, subdivision 1, is amended to read:

Subdivision 1. **Health care practitioner duties.** (a) Prior to a patient's enrollment in the registry program, a health care practitioner shall:

(1) determine, in the health care practitioner's medical judgment, whether a patient suffers from a qualifying medical condition, and, if so determined, provide the patient with a certification of that diagnosis;

(2) determine whether a patient is developmentally or physically disabled and, as a result of that disability, the patient ~~is unable to self-administer medication or acquire~~ requires

assistance in administering medical cannabis or obtaining medical cannabis from a distribution facility, and, if so determined, include that determination on the patient's certification of diagnosis;

(3) advise patients, registered designated caregivers, and parents ~~or~~, legal guardians, or spouses who are acting as caregivers of the existence of any nonprofit patient support groups or organizations;

(4) provide explanatory information from the commissioner to patients with qualifying medical conditions, including disclosure to all patients about the experimental nature of therapeutic use of medical cannabis; the possible risks, benefits, and side effects of the proposed treatment; the application and other materials from the commissioner; and provide patients with the Tennessen warning as required by section 13.04, subdivision 2; and

(5) agree to continue treatment of the patient's qualifying medical condition and report medical findings to the commissioner.

(b) Upon notification from the commissioner of the patient's enrollment in the registry program, the health care practitioner shall:

(1) participate in the patient registry reporting system under the guidance and supervision of the commissioner;

(2) report health records of the patient throughout the ongoing treatment of the patient to the commissioner in a manner determined by the commissioner and in accordance with subdivision 2;

(3) determine, on a yearly basis, if the patient continues to suffer from a qualifying medical condition and, if so, issue the patient a new certification of that diagnosis; and

(4) otherwise comply with all requirements developed by the commissioner.

(c) A health care practitioner may conduct a patient assessment to issue a recertification as required under paragraph (b), clause (3), via telemedicine as defined under section 62A.671, subdivision 9.

~~(c)~~ (d) Nothing in this section requires a health care practitioner to participate in the registry program.

Sec. 88. Minnesota Statutes 2018, section 152.29, subdivision 1, is amended to read:

Subdivision 1. **Manufacturer; requirements.** (a) A manufacturer shall operate ~~four~~ eight distribution facilities, which may include the manufacturer's single location for cultivation, harvesting, manufacturing, packaging, and processing but is not required to

include that location. ~~A manufacturer is required to begin distribution of medical cannabis from at least one distribution facility by July 1, 2015. All distribution facilities must be operational and begin distribution of medical cannabis by July 1, 2016. The distribution facilities shall be located~~ The commissioner shall designate the geographical service areas to be served by each manufacturer based on geographical need throughout the state to improve patient access. ~~A manufacturer shall disclose the proposed locations for the distribution facilities to the commissioner during the registration process.~~ A manufacturer shall not have more than two distribution facilities in each geographical service area assigned to the manufacturer by the commissioner. A manufacturer shall operate only one location where all cultivation, harvesting, manufacturing, packaging, and processing shall be conducted. ~~Any~~ This location may be one of the manufacturer's distribution facility sites. The additional distribution facilities may dispense medical cannabis and medical cannabis products but may not contain any medical cannabis in a form other than those forms allowed under section 152.22, subdivision 6, and the manufacturer shall not conduct any cultivation, harvesting, manufacturing, packaging, or processing at ~~an additional~~ the other distribution facility ~~site~~ sites. Any distribution facility operated by the manufacturer is subject to all of the requirements applying to the manufacturer under sections 152.22 to 152.37, including, but not limited to, security and distribution requirements.

(b) A manufacturer may acquire hemp from a hemp grower. A manufacturer may manufacture or process hemp into an allowable form of medical cannabis under section 152.22, subdivision 6. Hemp acquired by a manufacturer under this paragraph is subject to the same quality control program, security and testing requirements, and other requirements that apply to medical cannabis plant material under sections 152.22 to 152.37 and Minnesota Rules, chapter 4770.

~~(b)~~ (c) A medical cannabis manufacturer shall contract with a laboratory approved by the commissioner, subject to any additional requirements set by the commissioner, for purposes of testing medical cannabis manufactured by the medical cannabis manufacturer as to content, contamination, and consistency to verify the medical cannabis meets the requirements of section 152.22, subdivision 6. The cost of laboratory testing shall be paid by the manufacturer.

~~(c)~~ (d) The operating documents of a manufacturer must include:

(1) procedures for the oversight of the manufacturer and procedures to ensure accurate record keeping; ~~and~~

(2) procedures for the implementation of appropriate security measures to deter and prevent the theft of medical cannabis or hemp and unauthorized entrance into areas containing medical cannabis- or hemp; and

(3) procedures for the transportation and delivery of hemp from hemp growers to manufacturers.

~~(d)~~ (e) A manufacturer shall implement security requirements, including requirements for the transportation and delivery of hemp from hemp growers to manufacturers, protection of each location by a fully operational security alarm system, facility access controls, perimeter intrusion detection systems, and a personnel identification system.

~~(e)~~ (f) A manufacturer shall not share office space with, refer patients to a health care practitioner, or have any financial relationship with a health care practitioner.

~~(f)~~ (g) A manufacturer shall not permit any person to consume medical cannabis on the property of the manufacturer.

~~(g)~~ (h) A manufacturer is subject to reasonable inspection by the commissioner.

~~(h)~~ (i) For purposes of sections 152.22 to 152.37, a medical cannabis manufacturer is not subject to the Board of Pharmacy licensure or regulatory requirements under chapter 151.

~~(i)~~ (j) A medical cannabis manufacturer may not employ any person who is under 21 years of age or who has been convicted of a disqualifying felony offense. An employee of a medical cannabis manufacturer must submit a completed criminal history records check consent form, a full set of classifiable fingerprints, and the required fees for submission to the Bureau of Criminal Apprehension before an employee may begin working with the manufacturer. The bureau must conduct a Minnesota criminal history records check and the superintendent is authorized to exchange the fingerprints with the Federal Bureau of Investigation to obtain the applicant's national criminal history record information. The bureau shall return the results of the Minnesota and federal criminal history records checks to the commissioner.

~~(j)~~ (k) A manufacturer may not operate in any location, whether for distribution or cultivation, harvesting, manufacturing, packaging, or processing, within 1,000 feet of a public or private school existing before the date of the manufacturer's registration with the commissioner.

~~(k)~~ (l) A manufacturer shall comply with reasonable restrictions set by the commissioner relating to signage, marketing, display, and advertising of medical cannabis.

(m) Before a manufacturer acquires hemp from a hemp grower, the manufacturer must verify that the hemp grower has a valid license issued by the commissioner of agriculture under chapter 18K.

Sec. 89. Minnesota Statutes 2018, section 152.29, subdivision 2, is amended to read:

Subd. 2. **Manufacturer; production.** (a) A manufacturer of medical cannabis shall provide a reliable and ongoing supply of all medical cannabis needed for the registry program through cultivation by the manufacturer and through the purchase of hemp from hemp growers.

(b) All cultivation~~,~~ and harvesting performed by the manufacturer, and all manufacturing, packaging, and processing of medical cannabis and hemp, must take place in an enclosed, locked facility at a physical address provided to the commissioner during the registration process.

(c) A manufacturer must process and prepare any medical cannabis plant material or hemp plant material into a form allowable under section 152.22, subdivision 6, prior to distribution of any medical cannabis.

Sec. 90. Minnesota Statutes 2018, section 152.29, subdivision 3, is amended to read:

Subd. 3. **Manufacturer; distribution.** (a) A manufacturer shall require that employees licensed as pharmacists pursuant to chapter 151 be the only employees to give final approval for the distribution of medical cannabis to a patient. A manufacturer may transport medical cannabis or medical cannabis products that have been cultivated, harvested, manufactured, packaged, and processed by that manufacturer to another registered manufacturer for the other manufacturer to distribute.

(b) A manufacturer may ~~dispense~~ distribute medical cannabis products, whether or not the products have been manufactured by ~~the~~ that manufacturer~~, but is not required to dispense medical cannabis products~~.

(c) Prior to distribution of any medical cannabis, the manufacturer shall:

(1) verify that the manufacturer has received the registry verification from the commissioner for that individual patient;

(2) verify that the person requesting the distribution of medical cannabis is the patient, the patient's registered designated caregiver, or the patient's parent ~~or~~, legal guardian, or spouse listed in the registry verification using the procedures described in section 152.11, subdivision 2d;

(3) assign a tracking number to any medical cannabis distributed from the manufacturer;

(4) ensure that any employee of the manufacturer licensed as a pharmacist pursuant to chapter 151 has consulted with the patient to determine the proper dosage for the individual patient after reviewing the ranges of chemical compositions of the medical cannabis and the ranges of proper dosages reported by the commissioner. For purposes of this clause, a consultation may be conducted remotely using a videoconference, so long as the employee providing the consultation is able to confirm the identity of the patient, the consultation occurs while the patient is at a distribution facility, and the consultation adheres to patient privacy requirements that apply to health care services delivered through telemedicine;

(5) properly package medical cannabis in compliance with the United States Poison Prevention Packing Act regarding child-resistant packaging and exemptions for packaging for elderly patients, and label distributed medical cannabis with a list of all active ingredients and individually identifying information, including:

(i) the patient's name and date of birth;

(ii) the name and date of birth of the patient's registered designated caregiver or, if listed on the registry verification, the name of the patient's parent or legal guardian, if applicable;

(iii) the patient's registry identification number;

(iv) the chemical composition of the medical cannabis; and

(v) the dosage; and

(6) ensure that the medical cannabis distributed contains a maximum of a ~~30-day~~ 90-day supply of the dosage determined for that patient.

(d) A manufacturer shall require any employee of the manufacturer who is transporting medical cannabis or medical cannabis products to a distribution facility or to another registered manufacturer to carry identification showing that the person is an employee of the manufacturer.

Sec. 91. Minnesota Statutes 2018, section 152.31, is amended to read:

**152.31 DATA PRACTICES.**

(a) Government data in patient files maintained by the commissioner and the health care practitioner, and data submitted to or by a medical cannabis manufacturer, are private data on individuals, as defined in section 13.02, subdivision 12, or nonpublic data, as defined in section 13.02, subdivision 9, but may be used for purposes of complying with chapter 13 and complying with a request from the legislative auditor or the state auditor in the

performance of official duties. The provisions of section 13.05, subdivision 11, apply to a registration agreement entered between the commissioner and a medical cannabis manufacturer under section 152.25.

(b) Not public data maintained by the commissioner may not be used for any purpose not provided for in sections 152.22 to 152.37, and may not be combined or linked in any manner with any other list, dataset, or database.

(c) The commissioner may execute data sharing arrangements with the commissioner of agriculture to verify licensing, inspection, and compliance information related to hemp growers under chapter 18K.

Sec. 92. Minnesota Statutes 2018, section 152.32, subdivision 2, is amended to read:

Subd. 2. **Criminal and civil protections.** (a) Subject to section 152.23, the following are not violations under this chapter:

(1) use or possession of medical cannabis or medical cannabis products by a patient enrolled in the registry program, or possession by a registered designated caregiver or the parent ~~or~~, legal guardian, or spouse of a patient if the parent ~~or~~, legal guardian, or spouse is listed on the registry verification;

(2) possession, dosage determination, or sale of medical cannabis or medical cannabis products by a medical cannabis manufacturer, employees of a manufacturer, a laboratory conducting testing on medical cannabis, or employees of the laboratory; and

(3) possession of medical cannabis or medical cannabis products by any person while carrying out the duties required under sections 152.22 to 152.37.

(b) Medical cannabis obtained and distributed pursuant to sections 152.22 to 152.37 and associated property is not subject to forfeiture under sections 609.531 to 609.5316.

(c) The commissioner, the commissioner's staff, the commissioner's agents or contractors, and any health care practitioner are not subject to any civil or disciplinary penalties by the Board of Medical Practice, the Board of Nursing, or by any business, occupational, or professional licensing board or entity, solely for the participation in the registry program under sections 152.22 to 152.37. A pharmacist licensed under chapter 151 is not subject to any civil or disciplinary penalties by the Board of Pharmacy when acting in accordance with the provisions of sections 152.22 to 152.37. Nothing in this section affects a professional licensing board from taking action in response to violations of any other section of law.

(d) Notwithstanding any law to the contrary, the commissioner, the governor of Minnesota, or an employee of any state agency may not be held civilly or criminally liable for any injury, loss of property, personal injury, or death caused by any act or omission while acting within the scope of office or employment under sections 152.22 to 152.37.

(e) Federal, state, and local law enforcement authorities are prohibited from accessing the patient registry under sections 152.22 to 152.37 except when acting pursuant to a valid search warrant.

(f) Notwithstanding any law to the contrary, neither the commissioner nor a public employee may release data or information about an individual contained in any report, document, or registry created under sections 152.22 to 152.37 or any information obtained about a patient participating in the program, except as provided in sections 152.22 to 152.37.

(g) No information contained in a report, document, or registry or obtained from a patient under sections 152.22 to 152.37 may be admitted as evidence in a criminal proceeding unless independently obtained or in connection with a proceeding involving a violation of sections 152.22 to 152.37.

(h) Notwithstanding section 13.09, any person who violates paragraph (e) or (f) is guilty of a gross misdemeanor.

(i) An attorney may not be subject to disciplinary action by the Minnesota Supreme Court or professional responsibility board for providing legal assistance to prospective or registered manufacturers or others related to activity that is no longer subject to criminal penalties under state law pursuant to sections 152.22 to 152.37.

(j) Possession of a registry verification or application for enrollment in the program by a person entitled to possess or apply for enrollment in the registry program does not constitute probable cause or reasonable suspicion, nor shall it be used to support a search of the person or property of the person possessing or applying for the registry verification, or otherwise subject the person or property of the person to inspection by any governmental agency.

Sec. 93. Minnesota Statutes 2018, section 152.33, subdivision 1, is amended to read:

Subdivision 1. **Intentional diversion; criminal penalty.** In addition to any other applicable penalty in law, a manufacturer or an agent of a manufacturer who intentionally transfers medical cannabis to a person other than another registered manufacturer, a patient, a registered designated caregiver or, if listed on the registry verification, a parent ~~or~~, legal guardian, or spouse of a patient is guilty of a felony punishable by imprisonment for not more than two years or by payment of a fine of not more than $3,000, or both. A person

convicted under this subdivision may not continue to be affiliated with the manufacturer and is disqualified from further participation under sections 152.22 to 152.37.

Sec. 94. Minnesota Statutes 2018, section 152.33, subdivision 2, is amended to read:

Subd. 2. **Diversion by patient, registered designated caregiver, ~~or~~ parent, legal guardian, or patient's spouse; criminal penalty.** In addition to any other applicable penalty in law, a patient, registered designated caregiver or, if listed on the registry verification, a parent ~~or~~, legal guardian, or spouse of a patient who intentionally sells or otherwise transfers medical cannabis to a person other than a patient, designated registered caregiver or, if listed on the registry verification, a parent ~~or~~, legal guardian, or spouse of a patient is guilty of a felony punishable by imprisonment for not more than two years or by payment of a fine of not more than $3,000, or both.

Sec. 95. Minnesota Statutes 2018, section 152.34, is amended to read:

**152.34 HEALTH CARE FACILITIES.**

(a) Health care facilities licensed under chapter 144A, hospice providers licensed under chapter 144A, boarding care homes or supervised living facilities licensed under section 144.50, assisted living facilities, ~~and~~ facilities owned, controlled, managed, or under common control with hospitals licensed under chapter 144, and other health facilities licensed by the commissioner of health, may adopt reasonable restrictions on the use of medical cannabis by a patient enrolled in the registry program who resides at or is actively receiving treatment or care at the facility. The restrictions may include a provision that the facility will not store or maintain the patient's supply of medical cannabis, that the facility is not responsible for providing the medical cannabis for patients, and that medical cannabis be used only in a place specified by the facility.

(b) Any employee or agent of a facility listed in this section or a person licensed under chapter 144E is not subject to violations under this chapter for possession of medical cannabis while carrying out employment duties, including providing or supervising care to a registered patient, or distribution of medical cannabis to a registered patient who resides at or is actively receiving treatment or care at the facility with which the employee or agent is affiliated. Nothing in this section shall require the facilities to adopt such restrictions and no facility shall unreasonably limit a patient's access to or use of medical cannabis to the extent that use is authorized by the patient under sections 152.22 to 152.37.

Sec. 96. Minnesota Statutes 2018, section 152.36, subdivision 2, is amended to read:

Subd. 2. **Impact assessment.** The task force shall hold hearings to evaluate the impact of the use of medical cannabis and hemp and Minnesota's activities involving medical cannabis and hemp, including, but not limited to:

(1) program design and implementation;

(2) the impact on the health care provider community;

(3) patient experiences;

(4) the impact on the incidence of substance abuse;

(5) access to and quality of medical cannabis, hemp, and medical cannabis products;

(6) the impact on law enforcement and prosecutions;

(7) public awareness and perception; and

(8) any unintended consequences.

Sec. 97. Minnesota Statutes 2018, section 171.171, is amended to read:

**171.171 SUSPENSION; ILLEGAL PURCHASE OF ALCOHOL OR TOBACCO.**

The commissioner shall suspend for a period of 90 days the license of a person who:

(1) is under the age of 21 years and is convicted of purchasing or attempting to purchase an alcoholic beverage in violation of section 340A.503 if the person used a license, Minnesota identification card, or any type of false identification to purchase or attempt to purchase the alcoholic beverage;

(2) is convicted under section 171.22, subdivision 1, clause (2), or 340A.503, subdivision 2, clause (3), of lending or knowingly permitting a person under the age of 21 years to use the person's license, Minnesota identification card, or other type of identification to purchase or attempt to purchase an alcoholic beverage; or

~~(3) is under the age of 18 years and is found by a court to have committed a petty misdemeanor under section 609.685, subdivision 3, if the person used a license, Minnesota identification card, or any type of false identification to purchase or attempt to purchase the tobacco product; or~~

~~(4)~~ (3) is convicted under section 171.22, subdivision 1, clause (2), of lending or knowingly permitting a person under the age of ~~18~~ 21 years to use the person's license, Minnesota identification card, or other type of identification to purchase or attempt to

purchase ~~a tobacco product~~ tobacco, a tobacco-related device, an electronic delivery device, as defined in section 609.685, subdivision 1; or a nicotine or lobelia delivery product, as described in section 609.6855, subdivision 1.

Sec. 98. Minnesota Statutes 2018, section 214.25, subdivision 2, is amended to read:

Subd. 2. **Commissioner of health data.** ~~(a)~~ All data collected or maintained as part of the commissioner of health's duties under Minnesota Statutes 2018, sections 214.19, 214.23, and 214.24, shall be classified as investigative data under section 13.39, except that inactive investigative data shall be classified as private data under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9, in the case of data not on individuals.

~~(b) Notwithstanding section 13.05, subdivision 9, data addressed in this subdivision shall not be disclosed except as provided in this subdivision or section 13.04; except that the commissioner may disclose to the boards under section 214.23.~~

~~(c) The commissioner may disclose data addressed under this subdivision as necessary: to identify, establish, implement, and enforce a monitoring plan; to investigate a regulated person; to alert persons who may be threatened by illness as evidenced by epidemiologic data; to control or prevent the spread of HIV, HBV, or HCV disease; or to diminish an imminent threat to the public health.~~

**EFFECTIVE DATE.** This section is effective on January 1, 2020, and no new cases shall be investigated under this subdivision after June 1, 2019.

Sec. 99. Minnesota Statutes 2018, section 461.12, subdivision 2, is amended to read:

Subd. 2. **Administrative penalties for sales and furnishing; licensees.** If a licensee or employee of a licensee sells, gives, or otherwise furnishes tobacco, tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery products to a person under the age of ~~18~~ 21 years, or violates any other provision of this chapter, the licensee shall be charged an administrative penalty of ~~$75~~ $300 for the first violation. An administrative penalty of ~~$200~~ $600 must be imposed for a second violation at the same location within ~~24~~ 36 months after the initial violation. For a third or any subsequent violation at the same location within ~~24~~ 36 months after the initial violation, an administrative penalty of ~~$250~~ $1,000 must be imposed, and the licensee's authority to sell tobacco, tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery products at that location must be suspended for not less than seven days and may be revoked. No suspension, revocation, or other penalty may take effect until the licensee has received notice, served personally or by mail, of the alleged violation and an opportunity for a hearing before a person authorized

by the licensing authority to conduct the hearing. A decision that a violation has occurred must be in writing.

Sec. 100. Minnesota Statutes 2018, section 461.12, subdivision 3, is amended to read:

Subd. 3. **Administrative penalty for sales and furnishing; individuals.** An individual who sells, gives, or otherwise furnishes tobacco, tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery products to a person under the age of ~~18~~ 21 years ~~must~~ may be charged an administrative penalty of $50. No penalty may be imposed until the individual has received notice, served personally or by mail, of the alleged violation and an opportunity for a hearing before a person authorized by the licensing authority to conduct the hearing. A decision that a violation has occurred must be in writing.

Sec. 101. Minnesota Statutes 2018, section 461.12, subdivision 4, is amended to read:

Subd. 4. ~~**Minors**~~ **Alternative penalties for use of false identification; persons under age 21.** The licensing authority shall consult with interested persons, as applicable, including but not limited to educators, parents, ~~children~~ guardians, persons under the age of 21 years, and representatives of the court system to develop alternative penalties for ~~minors~~ persons under the age of 21 years who purchase, ~~possess, and consume~~ or attempt to purchase, tobacco, tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery products using a driver's license, permit, Minnesota identification card, or any other type of false identification to misrepresent the person's age, in violation of section 609.685 or 609.6855. The licensing authority and the interested persons shall consider a variety of alternative civil ~~options~~ penalties, including, but not limited to, ~~tobacco free~~ tobacco-free education; tobacco-cessation programs~~,~~; notice to schools~~,~~ and parents, or guardians; community service~~,~~; and ~~other~~ court diversion programs. Alternative civil penalties developed under this subdivision shall not include fines or monetary penalties.

Sec. 102. Minnesota Statutes 2018, section 461.12, subdivision 5, is amended to read:

Subd. 5. **Compliance checks.** (a) A licensing authority shall conduct unannounced compliance checks at least once each calendar year at each location where tobacco, tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery products are sold to test compliance with sections 609.685 and 609.6855. Compliance checks conducted under this subdivision must involve ~~minors~~ persons ~~over the age of 15~~ at least 17 years of age, but under the age of ~~18~~ 21, who, with the prior written consent of a parent or guardian if the person is under the age of 18, attempt to purchase tobacco, tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery products under the direct

supervision of a law enforcement officer or an employee of the licensing authority. The age requirements for persons participating in compliance checks under this subdivision shall not affect the age requirements in federal law for persons participating in federally required compliance checks of these locations.

(b) By January 15 of each year, a licensing authority must report the following information to the commissioner of human services:

(1) the total number of current licensees overseen by the licensing authority and the total number of compliance checks performed by the licensing authority in the preceding calendar year as required under paragraph (a); and

(2) the following information for each violation found in a retail compliance check required under paragraph (a) that was performed by the licensing authority in the preceding calendar year:

(i) the name of the licensing authority;

(ii) the date of the compliance check at which the violations were found;

(iii) the name and physical address of the licensee; and

(iv) the number of violations of sections 609.685 and 609.6855 by that licensee in the past 36 months.

The licensing authority may also report to the commissioner, a list of the products purchased during the compliance check and the penalty assessed on the licensee by the licensing authority. The commissioner shall compile all reports received from licensing authorities, make publicly available the information reported to the commissioner under this paragraph for the most recent five-year period, make publicly available the most recent list of licensees provided to the commissioner under subdivision 8, paragraph (b), and update the publicly available information at least annually.

Sec. 103. Minnesota Statutes 2018, section 461.12, subdivision 6, is amended to read:

Subd. 6. **Defense.** It is an affirmative defense to the charge of selling tobacco, tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery products to a person under the age of ~~18~~ 21 years in violation of subdivision 2 or 3 that the licensee or individual making the sale relied in good faith upon proof of age as described in section 340A.503, subdivision 6.

Sec. 104. Minnesota Statutes 2018, section 461.12, subdivision 8, is amended to read:

Subd. 8. **Notice to commissioner; information shared with commissioner of human services.** (a) The licensing authority under this section shall, within 30 days of the issuance of a license, inform the commissioner of revenue of the licensee's name, address, trade name, and the effective and expiration dates of the license. The commissioner of revenue must also be informed of a license renewal, transfer, cancellation, suspension, or revocation during the license period.

(b) The commissioner of revenue shall, by January 15 of each year, provide the commissioner of human services with a list of current licensees and shall provide the following information for each licensee: name, address, trade name, and effective date and expiration date of the license.

Sec. 105. Minnesota Statutes 2018, section 461.18, is amended to read:

**461.18 BAN ON SELF-SERVICE ~~SALE OF PACKS~~ SALES; EXCEPTIONS.**

Subdivision 1. **Except in ~~adult-only~~ facilities for persons 21 years of age and older.** (a) No person shall offer for sale tobacco or tobacco-related devices, or electronic delivery devices as defined in section 609.685, subdivision 1, or nicotine or lobelia delivery products as described in section 609.6855, in open displays which are accessible to the public without the intervention of a store employee.

~~(b) [Expired August 28, 1997]~~

~~(c) [Expired]~~

~~(d)~~ (b) This subdivision shall not apply to retail stores ~~which~~ that have an entrance door opening directly to the outside and that derive at least 90 percent of their gross revenue from the sale of tobacco ~~and~~, tobacco-related devices, and electronic delivery devices as defined in section 609.685, subdivision 1, and where the retailer ensures that no person ~~younger than 18 years of age~~ under the age of 21 years is present, or permitted to enter, at any time.

Subd. 2. **Vending machine sales prohibited.** No person shall sell tobacco products, electronic delivery devices, or nicotine or lobelia delivery products from vending machines. This subdivision does not apply to vending machines in facilities that cannot be entered at any time by persons ~~younger than 18~~ under the age of 21 years ~~of age~~.

Subd. 3. **Federal regulations for cartons, multipacks.** Code of Federal Regulations, title 21, part ~~897.16(c)~~ 1140.16(c), as amended from time to time, is incorporated by reference with respect to cartons and other multipack units.

Sec. 106. **[461.22] AGE VERIFICATION AND SIGNAGE REQUIRED.**

Subdivision 1. **Signage.** At each location where tobacco, tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery products are sold, the licensee shall display a sign in plain view to provide public notice that selling any of these products to any person under the age of 21 is illegal and subject to penalties. The notice shall be placed in a conspicuous location in the licensed establishment and shall be readily visible to any person who is purchasing or attempting to purchase these products. The sign shall provide notice that all persons responsible for selling these products must verify, by means of photographic identification containing the bearer's date of birth, the age of any person under 30 years of age.

Subd. 2. **Age verification.** At each location where tobacco, tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery products are sold, the licensee shall verify, by means of government-issued photographic identification containing the bearer's date of birth, that the purchaser or person attempting to make the purchase is at least 21 years of age. Verification is not required if the purchaser or person attempting to make the purchase is 30 years of age or older. It shall not constitute a defense to a violation of this subdivision that the person appeared to be 30 years of age or older.

Sec. 107. Minnesota Statutes 2018, section 609.685, is amended to read:

**609.685 SALE OF TOBACCO TO ~~CHILDREN~~ PERSONS UNDER AGE 21.**

Subdivision 1. **Definitions.** For the purposes of this section, the following terms shall have the meanings respectively ascribed to them in this section.

(a) "Tobacco" means cigarettes and any product containing, made, or derived from tobacco that is intended for human consumption, whether chewed, smoked, absorbed, dissolved, inhaled, snorted, sniffed, or ingested by any other means, or any component, part, or accessory of a tobacco product including but not limited to cigars; cheroots; stogies; perique; granulated, plug cut, crimp cut, ready rubbed, and other smoking tobacco; snuff; snuff flour; cavendish; plug and twist tobacco; fine cut and other chewing tobaccos; shorts; refuse scraps, clippings, cuttings and sweepings of tobacco; and other kinds and forms of tobacco. Tobacco excludes any ~~tobacco product that has been approved by the United States Food and Drug Administration for sale as a tobacco-cessation product, as a tobacco-dependence product, or for other medical purposes, and is being marketed and sold solely for such an approved purpose.~~ drugs, devices, or combination products, as those terms are defined in the Federal Food, Drug, and Cosmetic Act, that are authorized for sale by the United States Food and Drug Administration.

(b) "Tobacco-related devices" means cigarette papers or pipes for smoking or other devices intentionally designed or intended to be used in a manner which enables the chewing, sniffing, smoking, or inhalation of ~~vapors~~ aerosol or vapor of tobacco or tobacco products. Tobacco-related devices include components of tobacco-related devices which may be marketed or sold separately.

(c) "Electronic delivery device" means any product containing or delivering nicotine, lobelia, or any other substance, whether natural or synthetic, intended for human consumption ~~that can be used by a person to simulate smoking in the delivery of nicotine or any other substance~~ through inhalation of aerosol or vapor from the product. Electronic delivery devices includes but is not limited to devices manufactured, marketed, or sold as electronic cigarettes, electronic cigars, electronic pipe, vape pens, modes, tank systems, or under any other product name or descriptor. Electronic delivery device includes any component part of a product, whether or not marketed or sold separately. Electronic delivery device ~~does not include any product that has been approved or certified by the United States Food and Drug Administration for sale as a tobacco-cessation product, as a tobacco-dependence product, or for other medical purposes, and is marketed and sold for such an approved purpose.~~ excludes drugs, devices, or combination products, as those terms are defined in the Federal Food, Drug, and Cosmetic Act, that are authorized for sale by the United States Food and Drug Administration.

Subd. 1a. **Penalty to sell or furnish.** (a) ~~Whoever~~ Any person 21 years of age or older who sells, gives, or otherwise furnishes tobacco, tobacco-related devices, or electronic delivery devices to a person under the age of ~~18~~ 21 years is guilty of a petty misdemeanor for the first violation. Whoever violates this subdivision a subsequent time within five years of a previous conviction under this subdivision is guilty of a ~~gross~~ misdemeanor.

(b) It is an affirmative defense to a charge under this subdivision if the defendant proves by a preponderance of the evidence that the defendant reasonably and in good faith relied on proof of age as described in section 340A.503, subdivision 6.

Subd. 2. ~~**Other offenses**~~ **Use of false identification.** ~~(a) Whoever furnishes tobacco, tobacco-related devices, or electronic delivery devices to a person under the age of 18 years is guilty of a misdemeanor for the first violation. Whoever violates this paragraph a subsequent time is guilty of a gross misdemeanor.~~

~~(b)~~ A person under the age of ~~18~~ 21 years who purchases or attempts to purchase tobacco, tobacco-related devices, or electronic delivery devices and who uses a driver's license, permit, Minnesota identification card, or any type of false identification to misrepresent the

person's age, ~~is guilty of a misdemeanor~~ shall only be subject to an alternative civil penalty, in accordance with subdivision 2a.

Subd. 2a. **Alternative penalties.** Law enforcement and court system representatives shall consult, as applicable, with interested persons, including but not limited to parents, guardians, educators, and persons under the age of 21 years, to develop alternative civil penalties for persons under the age of 21 years who violate this section. Consulting participants shall consider a variety of alternative civil penalties including but not limited to tobacco-free education programs, community service, court diversion programs, and tobacco cessation programs, and for persons under the age of 18 years, notice to schools and to parents or guardians. Alternative civil penalties developed under this subdivision shall not include fines or monetary penalties.

~~Subd. 3. **Petty misdemeanor.** Except as otherwise provided in subdivision 2, whoever possesses, smokes, chews, or otherwise ingests, purchases, or attempts to purchase tobacco, tobacco-related devices, or electronic delivery devices and is under the age of 18 years is guilty of a petty misdemeanor.~~

Subd. 4. **Effect on local ordinances.** Nothing in subdivisions 1 to ~~3~~ 2a shall supersede or preclude the continuation or adoption of any local ordinance which provides for more stringent regulation of the subject matter in subdivisions 1 to ~~3~~ 2a.

Subd. 5. **Exceptions.** (a) Notwithstanding subdivision ~~2~~ 1a, an Indian may furnish tobacco to an Indian under the age of ~~18~~ 21 years if the tobacco is furnished as part of a traditional Indian spiritual or cultural ceremony. For purposes of this paragraph, an Indian is a person who is a member of an Indian tribe as defined in section 260.755, subdivision 12.

(b) The penalties in this section do not apply to a person under the age of ~~18~~ 21 years who purchases or attempts to purchase tobacco, tobacco-related devices, or electronic delivery devices while under the direct supervision of a responsible adult for training, education, research, or enforcement purposes.

Subd. 6. **Seizure of false identification.** A ~~retailer~~ licensee may seize a form of identification listed in section 340A.503, subdivision 6, if the ~~retailer~~ licensee has reasonable grounds to believe that the form of identification has been altered or falsified or is being used to violate any law. A ~~retailer~~ licensee that seizes a form of identification as authorized under this subdivision shall deliver it to a law enforcement agency within 24 hours of seizing it.

Sec. 108. Minnesota Statutes 2018, section 609.6855, is amended to read:

**609.6855 SALE OF NICOTINE DELIVERY PRODUCTS TO ~~CHILDREN~~ PERSONS UNDER AGE 21.**

Subdivision 1. **Penalty to sell or furnish.** (a) ~~Whoever~~ Any person 21 years of age or older who sells, gives, or otherwise furnishes to a person under the age of ~~18~~ 21 years a product containing or delivering nicotine or lobelia, whether natural or synthetic, intended for human consumption, or any part of such a product, that is not tobacco or an electronic delivery device as defined by section 609.685, is guilty of a petty misdemeanor for the first violation. Whoever violates this subdivision a subsequent time within five years of a previous conviction under this subdivision is guilty of a ~~gross~~ misdemeanor.

(b) It is an affirmative defense to a charge under this subdivision if the defendant proves by a preponderance of the evidence that the defendant reasonably and in good faith relied on proof of age as described in section 340A.503, subdivision 6.

(c) Notwithstanding paragraph (a), a product containing or delivering nicotine or lobelia intended for human consumption, whether natural or synthetic, or any part of such a product, that is not tobacco or an electronic delivery device as defined by section 609.685, may be sold to persons under the age of ~~18~~ 21 if the product ~~has been approved or otherwise certified for legal sale by the United States Food and Drug Administration for tobacco use cessation, harm reduction, or for other medical purposes, and is being marketed and sold solely for that approved purpose~~ is a drug, device, or combination product, as those terms are defined in the Federal Food, Drug, and Cosmetic Act, that are authorized for sale by the United States Food and Drug Administration.

Subd. 2. ~~**Other offense**~~ **Use of false identification.** A person under the age of ~~18~~ 21 years who purchases or attempts to purchase a product containing or delivering nicotine or lobelia intended for human consumption, or any part of such a product, that is not tobacco or an electronic delivery device as defined by section 609.685, and who uses a driver's license, permit, Minnesota identification card, or any type of false identification to misrepresent the person's age, ~~is guilty of a misdemeanor~~ shall only be subject to an alternative civil penalty in accordance with subdivision 3. No penalty shall apply to a person under the age of 21 years who purchases or attempts to purchase these products while under the direct supervision of a responsible adult for training, education, research, or enforcement purposes.

Subd. 3. ~~**Petty misdemeanor**~~ **Alternative penalties.** ~~Except as otherwise provided in subdivisions 1 and 2, whoever is under the age of 18 years and possesses, purchases, or~~

~~attempts to purchase a product containing or delivering nicotine or lobelia intended for human consumption, or any part of such a product, that is not tobacco or an electronic delivery device as defined by section 609.685, is guilty of a petty misdemeanor.~~ Law enforcement and court system representatives shall consult, as applicable, with interested persons, including but not limited to parents, guardians, educators, and persons under the age of 21 years, to develop alternative civil penalties for persons under the age of 21 years who violate this section. Consulting participants shall consider a variety of alternative civil penalties including but not limited to tobacco-free education programs, community service, court diversion programs, and tobacco cessation programs, and for persons under the age of 18 years, notice to schools and to parents or guardians. Alternative civil penalties developed under this subdivision shall not include fines or monetary penalties.

Sec. 109. **SKIN LIGHTENING PRODUCTS PUBLIC AWARENESS AND EDUCATION GRANT PROGRAM.**

Subdivision 1. **Establishment; purpose.** The commissioner of health shall develop a grant program for the purpose of increasing public awareness and education on the health dangers associated with using skin lightening creams and products that contain mercury that are manufactured in other countries and brought into this country and sold illegally online or in stores.

Subd. 2. **Grants authorized.** The commissioner shall award grants through a request for proposals process to community-based organizations serving ethnic communities, local public health entities, and nonprofit organizations that focus on providing health care and public health outreach to minorities. Priority shall be given to organizations that have historically served ethnic communities at significant risk from these products, but have not traditionally had access to state grant funding.

Subd. 3. **Grant allocation.** (a) Grantees must use the funds to conduct public awareness and education activities that are culturally specific and community-based and focus on:

(1) the dangers of exposure to mercury through dermal absorption, inhalation, hand-to-mouth contact, and through contact with individuals who have used these skin lightening products;

(2) the signs and symptoms of mercury poisoning;

(3) the health effects of mercury poisoning, including the permanent effects on the central nervous system and kidneys;

(4) the dangers of using these products or being exposed to these products during pregnancy and breastfeeding to the mother and to the infant;

(5) knowing how to identify products that contain mercury; and

(6) proper disposal of the product if the product contains mercury.

(b) The grant application must include:

(1) a description of the purpose or project for which the grant funds will be used;

(2) a description of the objectives, a work plan, and a timeline for implementation; and

(3) the community or group the grant proposes to focus on.

(c) The commissioner shall award 50 percent of the grant funds to community-based organizations and nonprofit organizations and 50 percent of the funds to local public health entities.

Sec. 110. **REVISOR INSTRUCTION.**

The revisor of statutes shall correct any internal cross-references to sections 214.17 to 214.25 that occur as a result of the repealed language and may make changes necessary to correct punctuation, grammar, or structure of the remaining text and preserve its meaning.

Sec. 111. **REPEALER.**

(a) Minnesota Statutes 2018, sections 144.414, subdivision 5; 144A.45, subdivision 6; and 144A.481, are repealed.

(b) Minnesota Statutes 2018, sections 214.17; 214.18; 214.19; 214.20; 214.21; 214.22; 214.23; and 214.24, are repealed on January 1, 2020, and no new cases shall be investigated under these sections after June 1, 2019.

## ARTICLE 13
## HEALTH COVERAGE

Section 1. Minnesota Statutes 2018, section 62A.021, is amended by adding a subdivision to read:

Subd. 1a. **Loss ratio standards.** (a) Health plans issued on the individual market must return to enrollees in the form of aggregate benefits not including anticipated refunds or credits, at least 80 percent of the aggregate amount of premiums earned.

(b) Health plans issued on the small employer market, as defined in section 62L.02, subdivision 27, must return to enrollees in the form of aggregate benefits not including anticipated refunds or credits, at least 82 percent of the aggregate amount of premiums earned.

(c) Health plans issued to large groups, meaning groups with 51 or more covered persons, must return to enrollees in the form of aggregate benefits not including anticipated refunds or credits, at least 85 percent of the aggregate amount of premiums earned.

(d) Short-term health plans, as defined in section 62A.65, subdivision 7, must return to enrollees in the form of aggregate benefits not to include anticipated refunds or credits, at least 80 percent of the aggregate amount of premiums earned.

(e) Health plans that are issued by a health maintenance organization or nonprofit health service plan corporation shall have loss ratios calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided on a service rather than reimbursement basis and earned premiums for the period and according to accepted actuarial principles and practices.

(f) A health carrier must submit to the commissioner a report, in a form and manner determined by the commissioner, evidencing compliance with this section. Information in the report must be aggregated and separated by individual, small employer, short-term, and large group market. The form must be submitted to the commissioner by June 1 of the year following the last calendar year during which the health carrier offered individual, small employer, or large group health plans.

(g) The commissioner shall review reports for actuarial reasonableness, soundness, and compliance with this section. If the report does not meet these requirements, the commissioner shall notify the health carrier in writing of the deficiency. The health carrier shall have 30 days from the date of the commissioner's notice to file an amended report that complies with this section. If the health carrier fails to file an amended report, the commissioner shall order the health carrier to issue a rebate calculated pursuant to subdivision 2a.

(h) A health plan that does not comply with the loss ratio requirements of this section is an unfair or deceptive act or practice in the business of insurance and is subject to the penalties in sections 72A.17 to 72A.32.

(i) The commissioners of commerce and health shall each annually issue a public report listing, by health carrier, the actual loss ratios experienced in the individual, small employer, short-term, and large group markets in this state by the health carriers that the commissioners

respectively regulate. The commissioners shall coordinate release of these reports so as to release them as a joint report or as separate reports issued the same day. The report or reports shall be released no later than September 1 for loss ratios experienced for the preceding calendar year. Health carriers shall provide to the commissioners any information requested by the commissioners for purposes of this paragraph.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 2. Minnesota Statutes 2018, section 62A.021, is amended by adding a subdivision to read:

Subd. 2a. **Rebate.** (a) A health carrier must issue a rebate to each enrollee if the health carrier's loss ratio does not meet or exceed the minimum required by subdivision 1a.

(b) The rebate must be in the amount of the aggregate amount of premiums earned, multiplied by the difference between the loss ratio the health carrier had for the prior calendar year and the loss ratio required under subdivision 1a.

(c) A health carrier must issue the rebate under paragraph (b) by August 1 of the year following the prior calendar year during which individual, small employer, short-term, or large group health plans were offered.

(d) The rebate must be paid in the form of a lump-sum check or lump-sum reimbursement to persons who are no longer enrolled in the health plan. The rebate may be paid either as a lump-sum check, a lump-sum reimbursement, or a direct deduction to the current plan year's premiums for current enrollees.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 3. Minnesota Statutes 2018, section 62A.021, is amended by adding a subdivision to read:

Subd. 3a. **Prohibiting subtractions from loss ratio calculations.** (a) A health carrier, when demonstrating compliance with the requirements of this section, shall subtract from incurred claims or incurred health expenses: (1) all reinsurance payments applied for or received under section 62E.23; and (2) all reimbursement payments made by the commissioner under sections 62A.25, subdivision 2, 62A.28, subdivision 2, 62A.3096, and 62A.3097.

(b) The commissioner, in reviewing this information, shall verify that health carriers have complied with the requirements of this subdivision.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 4. Minnesota Statutes 2018, section 62A.25, subdivision 2, is amended to read:

Subd. 2. **Required coverage.** (a) Every policy, plan, certificate or contract to which this section applies shall provide benefits for reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician.

(b) The coverage limitations on reconstructive surgery in paragraph (a) do not apply to reconstructive breast surgery: (1) following mastectomies; or (2) if the patient has been diagnosed with ectodermal dysplasia and has congenitally absent breast tissue or nipples. ~~In these cases, Coverage for reconstructive surgery must be provided if the mastectomy is medically necessary as determined by the attending physician.~~

(c) Reconstructive surgery benefits include all stages of reconstruction ~~of the breast on which the mastectomy has been performed~~, including surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications at all stages ~~of a mastectomy~~, including lymphedemas, in a manner determined in consultation with the attending physician and patient. Coverage may be subject to annual deductible, co-payment, and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Coverage may not:

(1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and

(2) penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

Written notice of the availability of the coverage must be delivered to the participant upon enrollment and annually thereafter.

(d) The commissioner of commerce shall reimburse health carriers for coverage of ectodermal dysplasias under this section. Reimbursement is available only for coverage that would not have been provided by the health carrier without the requirements of this section. Reimbursement from the commissioner shall be at the medical assistance rate. Health care

providers are prohibited from billing an enrollee for any amount in excess of the medical assistance rate. A provider is permitted to bill an enrollee for the applicable co-payment, deductible, or coinsurance.

**EFFECTIVE DATE.** This section is effective January 1, 2020, and applies to health plans offered, issued, or sold on or after that date.

Sec. 5. Minnesota Statutes 2018, section 62A.28, subdivision 2, is amended to read:

Subd. 2. **Required coverage.** (a) Every policy, plan, certificate, or contract referred to in subdivision 1 ~~issued or renewed after August 1, 1987,~~ must provide coverage for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata or ectodermal dysplasias.

(b) The coverage required by this section is subject to the co-payment, coinsurance, deductible, and other enrollee cost-sharing requirements that apply to similar types of items under the policy, plan, certificate, or contract and may be limited to one prosthesis per benefit year.

(c) The commissioner of commerce shall reimburse health carriers for coverage of ectodermal dysplasias under this section. Reimbursement is available only for coverage that would not have been provided by the health carrier without the requirements of this section. Reimbursement from the commissioner shall be at the medical assistance rate. Health care providers are prohibited from billing an enrollee for any amount in excess of the medical assistance rate. A provider is permitted to bill an enrollee for the applicable co-payment, deductible, or coinsurance.

**EFFECTIVE DATE.** This section is effective January 1, 2020, and applies to health plans offered, issued, or sold on or after that date.

Sec. 6. Minnesota Statutes 2018, section 62A.30, is amended by adding a subdivision to read:

Subd. 4. **Mammograms.** (a) For purposes of subdivision 2, coverage for a preventive mammogram screening (1) includes digital breast tomosynthesis for enrollees at risk for breast cancer, and (2) is covered as a preventive item or service, as described under section 62Q.46.

(b) For purposes of this subdivision, "digital breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to

produce cross-sectional digital three-dimensional images of the breast. "At risk for breast cancer" means:

(1) having a family history with one or more first- or second-degree relatives with breast cancer;

(2) testing positive for BRCA1 or BRCA2 mutations;

(3) having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or

(4) having a previous diagnosis of breast cancer.

(c) This subdivision does not apply to coverage provided through a public health care program under chapter 256B or 256L.

(d) Nothing in this subdivision limits the coverage of digital breast tomosynthesis in a policy, plan, certificate, or contract referred to in subdivision 1 that is in effect prior to January 1, 2020.

(e) Nothing in this subdivision prohibits a policy, plan, certificate, or contract referred to in subdivision 1 from covering digital breast tomosynthesis for an enrollee who is not at risk for breast cancer.

**EFFECTIVE DATE.** This section is effective January 1, 2020, and applies to health plans issued, sold, or renewed on or after that date.

Sec. 7. **[62A.3096] COVERAGE FOR ECTODERMAL DYSPLASIAS.**

Subdivision 1. **Definition.** For purposes of this chapter, "ectodermal dysplasias" means a genetic disorder involving the absence or deficiency of tissues and structures derived from the embryonic ectoderm.

Subd. 2. **Coverage.** A health plan must provide coverage for the treatment of ectodermal dysplasias.

Subd. 3. **Dental coverage.** (a) A health plan must provide coverage for dental treatments related to ectodermal dysplasias. Covered dental treatments must include but are not limited to bone grafts, dental implants, orthodontia, dental prosthodontics, and dental maintenance.

(b) If a dental treatment is eligible for coverage under a dental insurance plan or other health plan, the coverage under this subdivision is secondary.

Subd. 4. **Reimbursement.** The commissioner of commerce shall reimburse health carriers for coverage under this section. Reimbursement is available only for coverage that would

not have been provided by the health carrier without the requirements of this section. Reimbursement from the commissioner shall be at the medical assistance rate. Health care providers are prohibited from billing an enrollee for any amount in excess of the medical assistance rate. A provider is permitted to bill an enrollee for the applicable co-payment, deductible, or coinsurance.

**EFFECTIVE DATE.** This section is effective January 1, 2020, and applies to health plans offered, issued, or sold on or after that date.

Sec. 8. **[62A.3097] PEDIATRIC AUTOIMMUNE NEUROPSYCHIATRIC DISORDERS ASSOCIATED WITH STREPTOCOCCAL INFECTIONS (PANDAS) AND PEDIATRIC ACUTE-ONSET NEUROPSYCHIATRIC SYNDROME (PANS) TREATMENT; COVERAGE.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Pediatric acute-onset neuropsychiatric syndrome" means a class of acute-onset obsessive compulsive or tic disorders or other behavioral changes presenting in children and adolescents that are not otherwise explained by another known neurologic or medical disorder.

(c) "Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections" means a condition in which a streptococcal infection in a child or adolescent causes the abrupt onset of clinically significant obsessions, compulsions, tics, or other neuropsychiatric symptoms or behavioral changes, or a relapsing and remitting course of symptom severity.

Subd. 2. **Scope of coverage.** This section applies to all health plans that provide coverage to Minnesota residents.

Subd. 3. **Required coverage.** Every health plan included in subdivision 2 must provide coverage for treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and for treatment for pediatric acute-onset neuropsychiatric syndrome (PANS). Treatments that must be covered under this section must be recommended by the insured's licensed health care professional and include but are not limited to antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.

Subd. 4. **Reimbursement.** The commissioner of commerce shall reimburse health carriers for coverage under this section. Reimbursement is available only for coverage that would not have been provided by the health carrier without the requirements of this section.

Reimbursement from the commissioner shall be at the medical assistance rate. Health care providers are prohibited from billing an enrollee for any amount in excess of the medical assistance rate. A provider is permitted to bill an enrollee for the applicable co-payment, deductible, or coinsurance.

**EFFECTIVE DATE.** This section is effective January 1, 2020, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 9. Minnesota Statutes 2018, section 62A.65, subdivision 7, is amended to read:

Subd. 7. **Short-term coverage.** (a) For purposes of this section, "short-term coverage" means an individual health plan that:

(1) is issued to provide coverage for a period of ~~185~~ 90 days or less, except that the health plan may permit coverage to continue until the end of a period of hospitalization for a condition for which the covered person was hospitalized on the day that coverage would otherwise have ended;

(2) is nonrenewable, provided that the health carrier may provide coverage for one or more subsequent periods that satisfy clause (1), if the total of the periods of coverage do not exceed a total of ~~365~~ 185 days out of any 555-day period, plus any additional days covered as a result of hospitalization on the day that a period of coverage would otherwise have ended;

(3) does not cover any preexisting conditions, including ones that originated during a previous identical policy or contract with the same health carrier where coverage was continuous between the previous and the current policy or contract; and

(4) is available with an immediate effective date without underwriting upon receipt of a completed application indicating eligibility under the health carrier's eligibility requirements, provided that coverage that includes optional benefits may be offered on a basis that does not meet this requirement.

(b) Short-term coverage is not subject to subdivisions 2 and 5. Short-term coverage may exclude as a preexisting condition any injury, illness, or condition for which the covered person had medical treatment, symptoms, or any manifestations before the effective date of the coverage, but dependent children born or placed for adoption during the policy period must not be subject to this provision.

(c) Notwithstanding subdivision 3, and section 62A.021, a health carrier may combine short-term coverage with its most commonly sold individual qualified plan, as defined in

section 62E.02, other than short-term coverage, for purposes of complying with the loss ratio requirement.

(d) The ~~365-day~~ 185-day coverage limitation provided in paragraph (a) applies to the total number of days of short-term coverage that covers a person, regardless of the number of policies, contracts, or health carriers that provide the coverage. A written application for short-term coverage must ask the applicant whether the applicant has been covered by short-term coverage by any health carrier within the 555 days immediately preceding the effective date of the coverage being applied for. Short-term coverage issued in violation of the ~~365-day~~ 185-day limitation is valid until the end of its term and does not lose its status as short-term coverage, in spite of the violation. A health carrier that knowingly issues short-term coverage in violation of the ~~365-day~~ 185-day limitation is subject to the administrative penalties otherwise available to the commissioner of commerce or the commissioner of health, as appropriate.

**EFFECTIVE DATE.** This section is effective January 1, 2020, and applies to short-term coverage offered, issued, or renewed on or after that date.

Sec. 10. **[62C.045] APPLICATION OF OTHER LAWS.**

Chapter 317B and Laws 2017, First Special Session chapter 6, article 5, section 11, as amended by this act, apply to service plan corporations operating under this chapter.

Sec. 11. Minnesota Statutes 2018, section 62D.02, subdivision 4, is amended to read:

Subd. 4. **Health maintenance organization.** "Health maintenance organization" means a ~~foreign or domestic~~ nonprofit corporation organized under chapter 317A, or a local governmental unit as defined in subdivision 11, controlled and operated as provided in sections 62D.01 to 62D.30, which provides, either directly or through arrangements with providers or other persons, comprehensive health maintenance services, or arranges for the provision of these services, to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee.

Sec. 12. Minnesota Statutes 2018, section 62D.03, subdivision 1, is amended to read:

Subdivision 1. **Certificate of authority required.** Notwithstanding any law of this state to the contrary, any ~~foreign or domestic~~ nonprofit corporation organized to do so or a local governmental unit may apply to the commissioner of health for a certificate of authority to establish and operate a health maintenance organization in compliance with sections 62D.01 to 62D.30. No person shall establish or operate a health maintenance organization in this

state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization or health maintenance contract unless the organization has a certificate of authority under sections 62D.01 to 62D.30.

Sec. 13. **[62D.046] APPLICATION OF OTHER LAW.**

Chapter 317B applies to nonprofit health maintenance organizations operating under this chapter.

Sec. 14. Minnesota Statutes 2018, section 62D.05, subdivision 1, is amended to read:

Subdivision 1. **Authority granted.** Any nonprofit corporation or local governmental unit may, upon obtaining a certificate of authority as required in sections 62D.01 to 62D.30, operate as a health maintenance organization.

Sec. 15. Minnesota Statutes 2018, section 62D.06, subdivision 1, is amended to read:

Subdivision 1. **Governing body composition; enrollee advisory body.** The governing body of any health maintenance organization which is a nonprofit corporation may include enrollees, providers, or other individuals; provided, however, that after a health maintenance organization which is a nonprofit corporation has been authorized under sections 62D.01 to 62D.30 for one year, at least 40 percent of the governing body shall be composed of enrollees and members elected by the enrollees and members from among the enrollees and members. For purposes of this section, "member" means a consumer who receives health care services through a self-insured contract that is administered by the health maintenance organization or its related third-party administrator. The number of members elected to the governing body shall not exceed the number of enrollees elected to the governing body. An enrollee or member elected to the governing board may not be a person:

(1) whose occupation involves, or before retirement involved, the administration of health activities or the provision of health services;

(2) who is or was employed by a health care facility as a licensed health professional; or

(3) who has or had a direct substantial financial or managerial interest in the rendering of a health service, other than the payment of a reasonable expense reimbursement or compensation as a member of the board of a health maintenance organization.

After a health maintenance organization which is a local governmental unit has been authorized under sections 62D.01 to 62D.30 for one year, an enrollee advisory body shall be established. The enrollees who make up this advisory body shall be elected by the enrollees from among the enrollees.

Sec. 16. Minnesota Statutes 2018, section 62D.12, is amended by adding a subdivision to read:

Subd. 8a. **Net earnings.** All net earnings of a nonprofit health maintenance organization must be devoted to the nonprofit purposes of the health maintenance organization in providing comprehensive health care. A nonprofit health maintenance organization must not provide for the payment, whether directly or indirectly, of any part of its net earnings to any person for a purpose other than providing comprehensive health care, except that the health maintenance organization may make payments to providers or other persons based on the efficient provision of services or as incentives to provide quality care. The commissioner of health shall, pursuant to this chapter, revoke the certificate of authority of any nonprofit health maintenance organization in violation of this subdivision.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 17. Minnesota Statutes 2018, section 62D.124, subdivision 1, is amended to read:

Subdivision 1. **Emergency care; primary care; mental health services; general hospital services.** (a) Within the health maintenance organization's service area, the maximum travel distance or time shall be the lesser of 30 miles or 30 minutes to the nearest provider of each of the following services: primary care services, mental health services, and general hospital services. The health maintenance organization must designate which method is used.

(b) Emergency care must be available to enrollees 24 hours a day, 7 days a week. Appointment wait times for primary care services must not exceed 45 calendar days from the date of the enrollee's request for routine and preventive care and 48 hours for urgent care. Appointment wait times for mental health services and substance use disorder treatment services must not exceed 15 calendar days from the date of the enrollee's request for routine care and 24 hours for urgent care.

Sec. 18. Minnesota Statutes 2018, section 62D.124, subdivision 2, is amended to read:

Subd. 2. **Other health services.** (a) Within a health maintenance organization's service area, the maximum travel distance or time shall be the lesser of 60 miles or 60 minutes to

the nearest provider of specialty physician services, ancillary services, specialized hospital services, and all other health services not listed in subdivision 1. The health maintenance organization must designate which method is used.

(b) Appointment wait times for nonurgent specialty care must not exceed 60 calendar days from the date of the enrollee's request.

(c) Appointment wait time for dental, optometry, laboratory, and x-ray services must not exceed 45 calendar days from the date of the enrollee's request for regular appointments and 48 hours for urgent care. For purposes of this paragraph, regular appointments for dental care means preventive care and initial appointments for restorative care.

Sec. 19. Minnesota Statutes 2018, section 62D.124, subdivision 3, is amended to read:

Subd. 3. **~~Exception~~ Waiver.** ~~The commissioner shall grant an exception to the requirements of this section according to Minnesota Rules, part 4685.1010, subpart 4, if the health maintenance organization can demonstrate with specific data that the requirement of subdivision 1 or 2 is not feasible in a particular service area or part of a service area.~~ (a) A health maintenance organization may apply to the commissioner of health for a waiver of the requirements in subdivision 1 or 2 if it is unable to meet those requirements. A waiver application must be submitted on a form provided by the commissioner, must be accompanied by an application fee of $1,000 per county per year, for each application to waive the requirements in subdivision 1 or 2 for one or more provider types in that county, and must:

(1) demonstrate with specific data that the requirements of subdivision 1 or 2 are not feasible in a particular service area or part of a service area; and

(2) include specific information as to the steps that were and will be taken to address network inadequacy, and for steps that will be taken prospectively to address network inadequacy, the time frame within which those steps will be taken.

(b) Using the guidelines and standards established under section 62K.10, subdivision 5, paragraph (b), the commissioner shall review each waiver request and shall approve a waiver only if:

(1) the standards for approval established by the commissioner are satisfied; and

(2) the steps that were and will be taken to address the network inadequacy and the time frame for implementing these steps satisfy the standards established by the commissioner.

(c) If, in its waiver application, a health maintenance organization demonstrates to the commissioner that there are no providers of a specific type or specialty in a county, the

commissioner may approve a waiver in which the health maintenance organization is allowed to address network inadequacy in that county by providing for patient access to providers of that type or specialty via telemedicine, as defined in section 62A.671, subdivision 9.

(d) A waiver shall automatically expire after three years. Upon or prior to expiration of a waiver, a health maintenance organization unable to meet the requirements in subdivision 1 or 2 must submit a new waiver application under paragraph (a) and must also submit evidence of steps the organization took to address the network inadequacy. When the commissioner reviews a waiver application for a network adequacy requirement which has been waived for the organization for the most recent three-year period, the commissioner shall also examine the steps the organization took during that three-year period to address network inadequacy, and shall only approve a subsequent waiver application if it satisfies the requirements in paragraph (b), demonstrates that the organization took the steps it proposed to address network inadequacy, and explains why the organization continues to be unable to satisfy the requirements in subdivision 1 or 2.

(e) Application fees collected under this subdivision shall be deposited in the state government special revenue fund in the state treasury.

Sec. 20. Minnesota Statutes 2018, section 62D.124, is amended by adding a subdivision to read:

Subd. 6. **Complaints alleging violation of network adequacy requirements; investigation.** Enrollees of a health maintenance organization may file a complaint with the commissioner that the health maintenance organization is not in compliance with the requirements of subdivision 1 or 2, using the process established under section 62K.105, subdivision 1. The commissioner shall investigate all complaints received under this subdivision and may use the program established under section 62K.105, subdivision 2, to investigate complaints.

Sec. 21. Minnesota Statutes 2018, section 62D.124, is amended by adding a subdivision to read:

Subd. 7. **Provider network notifications.** A health maintenance organization must provide on the organization's website the provider network for each product offered by the organization, and must update the organization's website at least once a month with any changes to the organization's provider network, including provider changes from in-network status to out-of-network status. A health maintenance organization must also provide on the organization's website, for each product offered by the organization, a list of the current

waivers of the requirements in subdivision 1 or 2, in a format that is easily accessed and searchable by enrollees and prospective enrollees.

Sec. 22. Minnesota Statutes 2018, section 62D.17, subdivision 1, is amended to read:

Subdivision 1. **Administrative penalty.** The commissioner of health may, for any violation of statute or rule applicable to a health maintenance organization, or in lieu of suspension or revocation of a certificate of authority under section 62D.15, levy an administrative penalty in an amount up to $25,000 for each violation. In the case of contracts or agreements made pursuant to section 62D.05, subdivisions 2 to 4, each contract or agreement entered into or implemented in a manner which violates sections 62D.01 to 62D.30 shall be considered a separate violation. The commissioner shall impose an administrative penalty of at least $100 per day that a provider network in a county violates section 62D.124, subdivision 1 or 2, and may take other enforcement action authorized in law but shall not also impose an administrative penalty under section 62K.105, subdivision 3, for a violation. In determining the level of an administrative penalty, the commissioner shall consider the following factors:

(1) the number of enrollees affected by the violation;

(2) the effect of the violation on enrollees' health and access to health services;

(3) if only one enrollee is affected, the effect of the violation on that enrollee's health;

(4) whether the violation is an isolated incident or part of a pattern of violations; and

(5) the economic benefits derived by the health maintenance organization or a participating provider by virtue of the violation.

Reasonable notice in writing to the health maintenance organization shall be given of the intent to levy the penalty and the reasons therefor, and the health maintenance organization may have 15 days within which to file a written request for an administrative hearing and review of the commissioner of health's determination. Such administrative hearing shall be subject to judicial review pursuant to chapter 14. If an administrative penalty is levied, the commissioner must divide 50 percent of the amount among any enrollees affected by the violation, unless the commissioner certifies in writing that the division and distribution to enrollees would be too administratively complex or that the number of enrollees affected by the penalty would result in a distribution of less than $50 per enrollee.

Sec. 23. Minnesota Statutes 2018, section 62D.19, is amended to read:

**62D.19 UNREASONABLE EXPENSES.**

No health maintenance organization shall incur or pay for any expense of any nature which is unreasonably high in relation to the value of the service or goods provided. The commissioner of health shall implement and enforce this section by rules adopted under this section.

In an effort to achieve the stated purposes of sections 62D.01 to 62D.30, in order to safeguard the underlying nonprofit status of nonprofit health maintenance organizations, and to ensure that the payment of health maintenance organization money to major participating entities results in a corresponding benefit to the health maintenance organization and its enrollees, when determining whether an organization has incurred an unreasonable expense in relation to a major participating entity, due consideration shall be given to, in addition to any other appropriate factors, whether the officers and trustees of the health maintenance organization have acted with good faith and in the best interests of the health maintenance organization in entering into, and performing under, a contract under which the health maintenance organization has incurred an expense. The commissioner has standing to sue, on behalf of a health maintenance organization, officers or trustees of the health maintenance organization who have breached their fiduciary duty in entering into and performing such contracts.

Sec. 24. Minnesota Statutes 2018, section 62D.30, subdivision 8, is amended to read:

Subd. 8. **Rural demonstration project.** (a) The commissioner may permit demonstration projects to allow health maintenance organizations to extend coverage to a health improvement and purchasing coalition located in rural Minnesota, comprised of the health maintenance organization and members from a geographic area. For purposes of this subdivision, rural is defined as greater Minnesota excluding the seven-county metropolitan area of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington. The coalition must be designed in such a way that members will:

(1) become better informed about health care trends and cost increases;

(2) be actively engaged in the design of health benefit options that will meet the needs of their community;

(3) pool their insurance risk;

(4) purchase these products from the health maintenance organization involved in the demonstration project; and

(5) actively participate in health improvement decisions for their community.

(b) The commissioner must consider the following when approving applications for rural demonstration projects:

(1) the extent of consumer involvement in development of the project;

(2) the degree to which the project is likely to reduce the number of uninsured or to maintain existing coverage; and

(3) a plan to evaluate and report to the commissioner and legislature as prescribed by paragraph (e).

(c) For purposes of this subdivision, the commissioner must waive compliance with the following statutes and rules: the cost-sharing restrictions under section 62D.095, subdivisions 2, 3, and 4, and Minnesota Rules, part 4685.0801, subparts 1 to 7; for a period of at least two years, participation in government programs under section 62D.04, subdivision 5, in the counties of the demonstration project if that compliance would have been required solely due to participation in the demonstration project and shall continue to waive this requirement beyond two years if the enrollment in the demonstration project is less than 10,000 enrollees; small employer marketing under section 62L.05, subdivisions 1 to 3; and small employer geographic premium variations under section 62L.08, subdivision 4. The commissioner shall approve enrollee cost-sharing features desired by the coalition that appropriately share costs between employers, individuals, and the health maintenance organization.

(d) The health maintenance organization may make the starting date of the project contingent upon a minimum number of enrollees as cited in the application, provide for an initial term of contract with the purchasers of a minimum of three years, and impose a reasonable penalty for employers who withdraw early from the project. For purposes of this subdivision, loss ratios are to be determined as if the policies issued under this section are considered individual or small employer policies pursuant to section 62A.021, subdivision ~~1, paragraph (f)~~ 1a. The health maintenance organization may consider businesses of one to be a small employer under section 62L.02, subdivision 26. The health maintenance organization may limit enrollment and establish enrollment criteria for businesses of one. Health improvement and purchasing coalitions under this subdivision are not associations under section 62L.045, subdivision 1, paragraph (a).

(e) The health improvement and purchasing coalition must report to the commissioner and legislature annually on the progress of the demonstration project and, to the extent possible, any significant findings in the criteria listed in clauses (1), (2), and (3) for the final report. The coalition must submit a final report five years from the starting date of the

project. The final report must detail significant findings from the project and must include, to the extent available, but should not be limited to, information on the following:

(1) the extent to which the project had an impact on the number of uninsured in the project area;

(2) the effect on health coverage premiums for groups in the project's geographic area, including those purchasing health coverage outside the health improvement and purchasing coalition; and

(3) the degree to which health care consumers were involved in the development and implementation of the demonstration project.

(f) The commissioner must limit the number of demonstration projects under this subdivision to five projects.

(g) Approval of the application for the demonstration project is deemed to be in compliance with section 62E.06, subdivisions 1, paragraph (a), 2, and 3.

(h) Subdivisions 2 to 7 apply to demonstration projects under this subdivision. Waivers permitted under subdivision 1 do not apply to demonstration projects under this subdivision.

(i) If a demonstration project under this subdivision works in conjunction with a purchasing alliance formed under chapter 62T, that chapter will apply to the purchasing alliance except to the extent that chapter 62T is inconsistent with this subdivision.

Sec. 25. Minnesota Statutes 2018, section 62E.02, subdivision 3, is amended to read:

Subd. 3. **Health maintenance organization.** "Health maintenance organization" means a nonprofit corporation licensed and operated as provided in chapter 62D.

Sec. 26. Minnesota Statutes 2018, section 62E.23, subdivision 4, is amended to read:

Subd. 4. **Calculation of reinsurance payments.** (a) Each reinsurance payment must be calculated with respect to an eligible health carrier's incurred claims costs for an individual enrollee's covered benefits in the applicable benefit year. If the claims costs do not exceed the attachment point, the reinsurance payment is $0. If the claims costs exceed the attachment point, the reinsurance payment shall be calculated as the product of the coinsurance rate and the lesser of:

(1) the claims costs minus the attachment point; or

(2) the reinsurance cap minus the attachment point.

(b) The board must ensure that reinsurance payments made to eligible health carriers do not exceed the total amount paid by the eligible health carrier for any eligible claim. "Total amount paid of an eligible claim" means the amount paid by the eligible health carrier based upon the allowed amount less any deductible, coinsurance, or co-payment, as of the time the data are submitted or made accessible under subdivision 5, paragraph (c).

(c) In calculating claims costs incurred for an individual enrollee's covered benefits for a benefit year and eligible to be reimbursed by the commissioner of commerce, an eligible health carrier shall not include claims costs for coverage of ectodermal dysplasias or PANDAS or PANS under section 62A.25, subdivision 2; 62A.28, subdivision 2; 62A.3096; or 62A.3097.

**EFFECTIVE DATE.** This section is effective January 1, 2020, and applies to claims costs incurred on or after that date.

Sec. 27. Minnesota Statutes 2018, section 62K.075, is amended to read:

**62K.075 PROVIDER NETWORK NOTIFICATIONS.**

(a) A health carrier must provide on the carrier's website the provider network for each product offered by the carrier, and must update the carrier's website at least once a month with any changes to the carrier's provider network, including provider changes from in-network status to out-of-network status. A health carrier must also provide on the carrier's website, for each product offered by the carrier, a list of the current waivers of the requirements in section 62K.10, subdivision 2 or 3, in a format that is easily accessed and searchable by enrollees and prospective enrollees.

(b) Upon notification from an enrollee, a health carrier must reprocess any claim for services provided by a provider whose status has changed from in-network to out-of-network as an in-network claim if the service was provided after the network change went into effect but before the change was posted as required under paragraph (a) unless the health carrier notified the enrollee of the network change prior to the service being provided. This paragraph does not apply if the health carrier is able to verify that the health carrier's website displayed the correct provider network status on the health carrier's website at the time the service was provided.

(c) The limitations of section 62Q.56, subdivision 2a, shall apply to payments required by paragraph (b).

Sec. 28. Minnesota Statutes 2018, section 62K.10, subdivision 2, is amended to read:

Subd. 2. **Emergency care; primary care; mental health services; general hospital services.** (a) The maximum travel distance or time shall be the lesser of 30 miles or 30 minutes to the nearest provider of each of the following services: primary care services, mental health services, and general hospital services.

(b) Emergency care must be available to enrollees 24 hours a day, 7 days a week. A provider network must comply with the access standards for appointment wait times specified in section 62D.124, subdivision 1, paragraph (b), for primary care services, mental health services, and substance use disorder treatment services.

Sec. 29. Minnesota Statutes 2018, section 62K.10, subdivision 3, is amended to read:

Subd. 3. **Other health services.** (a) The maximum travel distance or time shall be the lesser of 60 miles or 60 minutes to the nearest provider of specialty physician services, ancillary services, specialized hospital services, and all other health services not listed in subdivision 2.

(b) A provider network must comply with the access standards for appointment wait times specified in section 62D.124, subdivision 2, paragraph (b), for nonurgent specialty care.

(c) A provider network must comply with the access standards for appointment wait times specified in section 62D.124, subdivision 2, paragraph (c), for dental, optometry, laboratory, and x-ray services.

Sec. 30. Minnesota Statutes 2018, section 62K.10, subdivision 4, is amended to read:

Subd. 4. **Network adequacy.** Each designated provider network must include a sufficient number and type of providers, including providers that specialize in mental health and substance use disorder services, to ensure that covered services are available to all enrollees without unreasonable delay. In determining network adequacy, the commissioner of health shall ensure that a provider network is sufficient to satisfy the access standards for emergency care and appointment wait times in subdivisions 2 and 3 and shall also consider availability of services, including the following:

(1) primary care physician services are available and accessible 24 hours per day, seven days per week, within the network area;

(2) a sufficient number of primary care physicians have hospital admitting privileges at one or more participating hospitals within the network area so that necessary admissions are made on a timely basis consistent with generally accepted practice parameters;

(3) specialty physician service is available through the network or contract arrangement;

(4) mental health and substance use disorder treatment providers are available and accessible through the network or contract arrangement;

(5) to the extent that primary care services are provided through primary care providers other than physicians, and to the extent permitted under applicable scope of practice in state law for a given provider, these services shall be available and accessible; and

(6) the network has available, either directly or through arrangements, appropriate and sufficient personnel, physical resources, and equipment to meet the projected needs of enrollees for covered health care services.

Sec. 31. Minnesota Statutes 2018, section 62K.10, subdivision 5, is amended to read:

Subd. 5. **Waiver.** (a) A health carrier ~~or preferred provider organization~~ may apply to the commissioner of health for a waiver of the requirements in subdivision 2 or 3 if it is unable to meet the statutory requirements. A waiver application must be submitted on a form provided by the commissioner, must be accompanied by an application fee of $1,000 for each application to waive the requirements in subdivision 2 or 3 for one or more provider types per county, and must:

(1) demonstrate with specific data that the requirement of subdivision 2 or 3 is not feasible in a particular service area or part of a service area; and

(2) include specific information as to the steps that were and will be taken to address the network inadequacy, and for steps that will be taken prospectively to address network inadequacy, the time frame within which those steps will be taken.

(b) The commissioner shall establish guidelines for evaluating waiver applications, standards governing approval or denial of a waiver application, and standards for steps that health carriers must take to address the network inadequacy and allow the health carrier to meet network adequacy requirements within a reasonable time period. The commissioner shall review each waiver application using these guidelines and standards and shall approve a waiver application only if:

(1) the standards for approval established by the commissioner are satisfied; and

(2) the steps that were and will be taken to address the network inadequacy and the time frame for taking these steps satisfy the standards established by the commissioner.

(c) If, in its waiver application, a health carrier demonstrates to the commissioner that there are no providers of a specific type or specialty in a county, the commissioner may approve a waiver in which the health carrier is allowed to address network inadequacy in that county by providing for patient access to providers of that type or specialty via telemedicine, as defined in section 62A.671, subdivision 9.

(d) The waiver shall automatically expire after ~~four years. If a renewal of the waiver is sought, the commissioner of health shall take into consideration steps that have been taken to address network adequacy.~~ one year. Upon or prior to expiration of a waiver, a health carrier unable to meet the requirements in subdivision 2 or 3 must submit a new waiver application under paragraph (a) and must also submit evidence of steps the carrier took to address the network inadequacy. When the commissioner reviews a waiver application for a network adequacy requirement which has been waived for the carrier for the most recent one-year period, the commissioner shall also examine the steps the carrier took during that one-year period to address network inadequacy, and shall only approve a subsequent waiver application that satisfies the requirements in paragraph (b), demonstrates that the carrier took the steps it proposed to address network inadequacy, and explains why the carrier continues to be unable to satisfy the requirements in subdivision 2 or 3.

(e) Application fees collected under this subdivision shall be deposited in the state government special revenue fund in the state treasury.

Sec. 32. **[62K.105] NETWORK ADEQUACY COMPLAINTS AND INVESTIGATIONS.**

Subdivision 1. **Complaints.** The commissioner shall establish a clear, easily accessible process for accepting complaints from enrollees regarding health carrier compliance with section 62K.10, subdivision 2, 3, or 4. Using this process, an enrollee may file a complaint with the commissioner that a health carrier is not in compliance with the requirements of section 62K.10, subdivision 2, 3, or 4. The commissioner shall investigate all complaints received under this subdivision.

Subd. 2. **Commissioner investigations of provider networks.** The commissioner shall establish a program to examine health carrier compliance with the requirements in section 62K.10, subdivisions 2, 3, and 4. Under this program, department employees or contractors shall seek to make appointments with a range of provider types in a carrier's designated provider network to determine whether covered services are available to enrollees within

the required appointment times, and shall examine whether the carrier's network complies with the maximum distance or travel time requirements for specific provider types. The commissioner shall develop a schedule to ensure that all health carriers are periodically examined under this program, and shall also use this program to investigate enrollee complaints filed under subdivision 1.

Subd. 3. **Administrative penalties.** The commissioner shall impose on a health carrier an administrative penalty of at least $100 per day that a provider network violates section 62K.10, subdivision 2, 3, or 4, in a county. The commissioner may also take other enforcement actions authorized in law for a violation, except that if the commissioner imposes an administrative penalty under this subdivision, the commissioner shall not also impose an administrative penalty under section 62D.17, subdivision 1. The commissioner shall use the factors in section 62D.17, subdivision 1, to determine the amount of the administrative penalty, and the procedures in section 62D.17, subdivision 1, apply to administrative penalties imposed under this subdivision.

Sec. 33. Minnesota Statutes 2018, section 62Q.01, is amended by adding a subdivision to read:

Subd. 6b. **Nonquantitative treatment limitations or NQTLs.** "Nonquantitative treatment limitations" or "NQTLs" means processes, strategies, or evidentiary standards, or other factors that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. NQTLs include but are not limited to:

(1) medical management standards limiting or excluding benefits based on (i) medical necessity or medical appropriateness, or (ii) whether the treatment is experimental or investigative;

(2) formulary design for prescription drugs;

(3) health plans with multiple network tiers;

(4) criteria and parameters for provider inclusion in provider networks, including credentialing standards and reimbursement rates;

(5) health plan methods for determining usual, customary, and reasonable charges;

(6) fail-first or step therapy protocols;

(7) exclusions based on failure to complete a course of treatment;

(8) restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the health plan;

(9) in- and out-of-network geographic limitations;

(10) standards for providing access to out-of-network providers;

(11) limitations on inpatient services for situations where the enrollee is a threat to self or others;

(12) exclusions for court-ordered and involuntary holds;

(13) experimental treatment limitations;

(14) service coding;

(15) exclusions for services provided by clinical social workers; and

(16) provider reimbursement rates, including rates of reimbursement for mental health and substance use disorder services in primary care.

Sec. 34. **[62Q.1841] PROHIBITION ON USE OF STEP THERAPY FOR METASTATIC CANCER.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Health plan" has the meaning given in section 62Q.01, subdivision 3. Health plan includes health coverage provided by a county-based purchasing plan participating in a public program under chapter 256B or 256L or an integrated health partnership under section 256B.0755.

(c) "Stage four advanced metastatic cancer" means cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other parts of the body.

(d) "Step therapy protocol" has the meaning given in section 62Q.184, subdivision 1.

Subd. 2. **Prohibition on use of step therapy protocols.** A health plan that provides coverage for the treatment of stage four advanced metastatic cancer or associated conditions must not limit or exclude coverage for a drug approved by the United States Food and Drug Administration that is on the health plan's prescription drug formulary by mandating that an enrollee with stage four advanced metastatic cancer or associated conditions follow a step therapy protocol if the use of the approved drug is consistent with:

(1) a United States Food and Drug Administration-approved indication; and

(2) a clinical practice guideline published by the National Comprehensive Care Network.

**EFFECTIVE DATE.** This section is effective January 1, 2020, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 35. Minnesota Statutes 2018, section 62Q.47, is amended to read:

**62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES.**

(a) All health plans, as defined in section 62Q.01, that provide coverage for alcoholism, mental health, or chemical dependency services, must comply with the requirements of this section.

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

(d) A health plan must not impose an NQTL with respect to mental health and substance use disorders in any classification of benefits unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health and substance use disorders in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to medical and surgical benefits in the same classification.

~~(d)~~ (e) All health plans must meet the requirements of the federal Mental Health Parity Act of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and federal guidance or regulations issued under, those acts.

(f) The commissioner, in consultation with advocates, providers, and health plan companies, may require information from health plan companies to confirm that mental health parity is being implemented. Information required may include comparisons between mental health and substance use disorder treatment against other health care conditions for other issues, including wait times, prior authorizations, provider credentialing and reimbursement, drug formularies, use of out-of-network providers, out-of-pocket costs, medical necessity, network adequacy, claim denials, adoption of coverage for new treatments, in-home services, rehabilitation services, and other information the commissioner deems appropriate.

(g) Regardless of the care provider's professional license, if the care is consistent with the provider's scope of practice and the health plan's credentialing and contracting provisions, mental health therapy visits and medication maintenance visits are considered primary care visits for the purposes of applying any patient cost-sharing requirements imposed by the health plan. Beginning June 1, 2021, and each year thereafter, the commissioner of commerce, in consultation with the commissioner of health, must issue an updated report to the legislature. The report must:

(1) describe how the commissioners review health plan compliance with United States Code, title 42, section 18031(j), and any federal regulations or guidance relating to compliance and oversight;

(2) describe how the commissioners review compliance with this section and section 62Q.53;

(3) identify enforcement actions taken during the preceding 12-month period regarding compliance with parity for mental health and substance use disorders benefits under state and federal law and summarize the results of such market conduct examinations. The summary must include:

(i) the number of formal enforcement actions taken;

(ii) the benefit classifications examined in each enforcement action;

(iii) the subject matter of each enforcement action, including quantitative and nonquantitative treatment limitations; and

(iv) a description of how individually identifiable information will be excluded from the reports, consistent with state and federal privacy protections;

(4) detail any corrective actions the commissioners have taken to ensure health plan compliance with this section and section 62Q.53, and United States Code, title 42, section 18031(j);

(5) detail the approach taken by the commissioners relating to informing the public about alcoholism, mental health, or chemical dependency parity protections under state and federal law; and

(6) be written in nontechnical, readily understandable language and must be made available to the public by, among other means as the commissioners find appropriate, posting the report on department websites.

Sec. 36. **[62Q.521] COVERAGE OF CONTRACEPTIVE METHODS AND SERVICES.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Closely held for-profit entity" means an entity that:

(1) is not a nonprofit entity;

(2) has more than 50 percent of the value of its ownership interest owned directly or indirectly by five or fewer individuals, or has an ownership structure that is substantially similar; and

(3) has no publicly traded ownership interest, having any class of common equity securities required to be registered under United States Code, title 15, section 781.

For purposes of this paragraph:

(i) ownership interests owned by a corporation, partnership, estate, or trust are considered owned proportionately by that entity's shareholders, partners, or beneficiaries;

(ii) ownership interests owned by a nonprofit entity are considered owned by a single owner;

(iii) ownership interests owned by an individual are considered owned, directly or indirectly, by or for the individual's family. For purposes of this item, "family" means brothers and sisters, including half-brothers and half-sisters, a spouse, ancestors, and lineal descendants; and

(iv) if an individual or entity holds an option to purchase an ownership interest, the individual or entity is considered to be the owner of those ownership interests.

(c) "Contraceptive method" means a drug, device, or other product approved by the Food and Drug Administration to prevent unintended pregnancy.

(d) "Contraceptive service" means consultation, examination, procedures, and medical services related to the prevention of unintended pregnancy. This includes but is not limited to voluntary sterilization procedures, patient education, counseling on contraceptives, and follow-up services related to contraceptive methods or services, management of side effects, counseling for continued adherence, and device insertion or removal.

(e) "Eligible organization" means an organization that opposes providing coverage for some or all contraceptive methods or services on account of religious objections and that is:

(1) organized as a nonprofit entity and holds itself as a religious organization; or

(2) organized and operates as a closely held for-profit entity, and the organization's highest governing body has adopted, under the organization's applicable rules of governance and consistent with state law, a resolution or similar action establishing that it objects to covering some or all contraceptive methods or services on account of the owners' sincerely held religious beliefs.

(f) "Medical necessity" includes but is not limited to considerations such as severity of side effects, difference in permanence and reversibility of a contraceptive method or service, and ability to adhere to the appropriate use of the contraceptive method or service, as determined by the attending provider.

(g) "Religious employer" means an organization that is organized and operates as a nonprofit entity and meets the requirements of section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

(h) "Therapeutic equivalent version" means a drug, device, or product that can be expected to have the same clinical effect and safety profile when administered to a patient under the conditions specified in the labeling, and that:

(1) is approved as safe and effective;

(2) is a pharmaceutical equivalent, (i) containing identical amounts of the same active drug ingredient in the same dosage form and route of administration, and (ii) meeting compendial or other applicable standards of strength, quality, purity, and identity;

(3) is bioequivalent in that:

(i) the drug, device, or product does not present a known or potential bioequivalence problem and meet an acceptable in vitro standard; or

(ii) if the drug, device, or product does present a known or potential bioequivalence problem, it is shown to meet an appropriate bioequivalence standard;

(4) is adequately labeled; and

(5) is manufactured in compliance with current manufacturing practice regulations.

Subd. 2. **Required coverage; cost sharing prohibited.** (a) A health plan must provide coverage for contraceptive methods and services.

(b) A health plan company must not impose cost-sharing requirements, including co-pays, deductibles, or co-insurance, for contraceptive methods or services.

(c) Notwithstanding paragraph (b), a health plan that is a high-deductible health plan in conjunction with a health savings account must include cost-sharing for contraceptive methods and services at the minimum level necessary to preserve the enrollee's ability to make tax exempt contributions and withdrawals from the health savings account, as provided by section 223 of the Internal Revenue Code of 1986, as amended.

(d) A health plan company must not impose any referral requirements, restrictions, or delays for contraceptive methods or services.

(e) A health plan must include at least one of each type of Food and Drug Administration approved contraceptive method in its formulary. If more than one therapeutic equivalent version of a contraceptive method is approved, a health plan must include at least one therapeutic equivalent version in its formulary, but is not required to include all therapeutic equivalent versions.

(f) For each health plan, a health plan company must list the contraceptive methods and services that are covered without cost-sharing in a manner that is easily accessible to enrollees, health care providers, and representatives of health care providers. The list for each health plan must be promptly updated to reflect changes to the coverage.

(g) If an enrollee's attending provider recommends a particular contraceptive method or service based on a determination of medical necessity for that enrollee, the health plan must cover that contraceptive method or service without cost-sharing. The health plan company issuing the health plan must defer to the attending provider's determination that the particular contraceptive method or service is medically necessary for the enrollee.

Subd. 3. **Religious employers; exempt** (a) A religious employer is not required to cover contraceptive methods or services if the employer has religious objections to the coverage. A religious employer that chooses to not provide coverage for contraceptive methods and services must notify employees as part of the hiring process and total employees at least 30 days before:

(1) an employee enrolls in the health plan; or

(2) the effective date of the health plan, whichever occurs first.

(b) If the religious employer provides coverage for some contraceptive methods or services, the notice must provide a list of the contraceptive methods or services the employer refuses to cover.

Subd. 4. **Accommodation for eligible organizations.** (a) A health plan established or maintained by an eligible organization complies with the requirements of subdivision 2 to provide coverage of contraceptive methods and services if the eligible organization provides notice to any health plan company the eligible organization contracts with that it is an eligible organization and that the eligible organization has a religious objection to coverage for all or a subset of contraceptive methods or services.

(b) The notice from an eligible organization to a health plan company under paragraph (a) must include the name of the eligible organization, a statement that it objects to coverage for some or all of contraceptive methods or services, including a list of the contraceptive methods or services the eligible organization objects to, if applicable, and the health plan name. The notice must be executed by a person authorized to provide notice on behalf of the eligible organization.

(c) An eligible organization must provide a copy of the notice under paragraph (b) to prospective employees as part of the hiring process and total employees at least 30 days before:

(1) an employee enrolls in the health plan; or

(2) the effective date of the health plan, whichever occurs first.

(d) A health plan company that receives a copy of the notice under paragraph (a) with respect to a health plan established or maintained by an eligible organization must:

(1) expressly exclude coverage for some or all contraceptive methods or services from the health plan; and

(2) provide separate payments for any contraceptive methods or services required to be covered under subdivision 2 for enrollees as long as the enrollee remains enrolled in the health plan.

(e) The health plan company must not impose any cost-sharing requirements, including co-pays, deductibles, or co-insurance, or directly or indirectly impose any premium, fee, or other charge for contraceptive services or methods on the eligible organization, health plan, or enrollee.

(f) On January 1, 2021, and every year thereafter a health plan company must notify the commissioner, in a manner to be determined by the commissioner, regarding the number of eligible organizations granted an accommodation under this subdivision.

**EFFECTIVE DATE.** This section is effective January 1, 2021, and applies to coverage offered, sold, issued, or renewed on or after that date.

Sec. 37. **[62Q.522] COVERAGE FOR PRESCRIPTION CONTRACEPTIVES; SUPPLY REQUIREMENTS.**

Subdivision 1. **Scope of coverage.** Except as otherwise provided in section 62Q.521, subdivision 3, all health plans that provide prescription coverage must comply with the requirements of this section.

Subd. 2. **Definition.** For purposes of this section, "prescription contraceptive" means any drug or device that requires a prescription and is approved by the Food and Drug Administration to prevent pregnancy. Prescription contraceptive does not include an emergency contraceptive drug that prevents pregnancy when administered after sexual contact.

Subd. 3. **Required coverage.** (a) Health plan coverage for a prescription contraceptive must provide a 12-month supply for any prescription contraceptive, regardless of whether the enrollee was covered by the health plan at the time of the first dispensing.

(b) The prescribing health care provider must determine the appropriate number of months to prescribe the prescription contraceptives for, up to 12 months.

**EFFECTIVE DATE.** This section is effective January 1, 2021, and applies to coverage offered, sold, issued, or renewed on or after that date.

Sec. 38. Minnesota Statutes 2018, section 62Q.81, is amended to read:

**62Q.81 ESSENTIAL HEALTH BENEFIT PACKAGE REQUIREMENTS.**

Subdivision 1. **Essential health benefits package.** (a) Health plan companies offering individual and small group health plans must include the essential health benefits package ~~required under section 1302(a) of the Affordable Care Act and~~ as described in this subdivision.

(b) The essential health benefits package means coverage that:

(1) provides essential health benefits as ~~outlined in the Affordable Care Act~~ described in subdivision 4;

(2) limits cost-sharing for such coverage ~~in accordance with the Affordable Care Act,~~ as described in subdivision 2; and

(3) ~~subject to subdivision 3,~~ provides bronze, silver, gold, or platinum level of coverage ~~in accordance with the Affordable Care Act~~ as described in subdivision 3.

Subd. 2. **Cost-sharing; coverage for enrollees under the age of 21.** (a) Cost-sharing includes deductibles, coinsurance, co-payments, or similar charges, and qualified medical expenses, as defined in section 223(d)(2) of the Internal Revenue Code of 1986, as amended. It does not include premiums, balance billing from non-network providers, or spending for noncovered services.

(b) Cost-sharing per year for individual health plans is limited to the amount allowed under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986, as amended, increased by an amount equal to the product of that amount and the premium adjustment percentage. The premium adjustment percentage is the percentage which the average per capita premium for health insurance coverage in the United States for the preceding calendar year exceeds the average per capita premium for 2017. If the amount of the increase is not a multiple of $50, the increases shall be rounded to the next lowest multiple of $50.

(c) Cost-sharing per year for small group health plans is limited to twice the amount allowed under paragraph (b).

(d) If a health plan company offers health plans in any level of coverage ~~specified under section 1302(d) of the Affordable Care Act,~~ as described in subdivision ~~1, paragraph (b), clause (3)~~ 3, the health plan company shall also offer coverage in that level to individuals who have not attained 21 years of age as of the beginning of a policy year.

Subd. 3. **Levels of coverage; alternative compliance for catastrophic plans.** (a) A health plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

(b) A health plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

(c) A health plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

(d) A health plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(e) A health plan company that does not provide an individual or small group health plan in the bronze, silver, gold, or platinum level of coverage~~, as described in subdivision 1, paragraph (b), clause (3),~~ shall be treated as meeting the requirements of this section ~~1302(d) of the Affordable Care Act~~ with respect to any ~~policy~~ plan year if the health plan company provides a catastrophic plan that meets the following requirements ~~of section 1302(e) of the Affordable Care Act.~~:

(1) the only individuals to enroll in the health plan are those that:

(i) have not attained age 30 before the beginning of the plan year;

(ii) have an inability to access affordable coverage; or

(iii) are experiencing a hardship in reference to their capability to access coverage; and

(2) the health plan provides essential health benefits, except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in the amount equal to the limitation in effect under subdivision 2 and the plan provides coverage for at least three primary care visits.

Subd. 4. **Essential health benefits; definition.** (a) For purposes of this section, "essential health benefits" ~~has the meaning given under section 1302(b) of the Affordable Care Act and includes~~ means:

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) laboratory services;

(5) maternity and newborn care;

(6) mental health and substance use disorder services, including behavioral health treatment;

(7) pediatric services, including oral and vision care;

(8) prescription drugs;

(9) preventive and wellness services and chronic disease management;

(10) rehabilitative and habilitative services and devices; and

(11) additional essential health benefits included in the ~~EHB-benchmark plan, as defined under the Affordable Care Act~~ health plan described in paragraph (c).

(b) Emergency services must be provided without imposing any prior authorization requirement or limitation on coverage, where the provider of services does not have a contractual relationship with the health plan for the providing of services, that is more restrictive than the requirements or limitations that apply to emergency services received from providers who have a contractual relationship with the health plan. If services are provided out-of-network the cost-sharing is the same that would apply if services were provided in-network.

(c) The scope of essential health benefits under paragraph (a) must be equal to the scope of benefits provided under a typical employer plan.

(d) The essential health benefits must:

(1) reflect an appropriate balance among the categories so that benefits are not unduly weighted toward any category;

(2) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(3) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups; and

(4) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of

life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life.

Subd. 5. **Exception.** This section does not apply to a dental plan ~~described in section 1311(d)(2)(B)(ii) of the Affordable Care Act~~ that is limited in scope and provides pediatric dental benefits.

Sec. 39. Minnesota Statutes 2018, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner or as provided in paragraph (g).

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

(1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and

pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals. Over-the-counter medications must be dispensed in a quantity that is the lowest of: (1) the number of dosage units contained in the manufacturer's original package; (2) the number of dosage units required to complete the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed from a system using retrospective billing, as provided under subdivision 13e, paragraph (b).

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

(g) Medical assistance coverage for a prescription contraceptive must provide a 12-month supply for any prescription contraceptive, regardless of whether the enrollee was covered by medical assistance or the health plan at the time of the first dispensing. The prescribing health care provider must determine the appropriate number of months to prescribe the prescription contraceptives for, up to 12 months.

For purposes of this paragraph, "prescription contraceptive" means any drug or device that requires a prescription and is approved by the Food and Drug Administration to prevent pregnancy. Prescription contraceptive does not include an emergency contraceptive drug

approved to prevent pregnancy when administered after sexual contact. For purposes of this paragraph, "health plan" has the meaning provided in section 62Q.01, subdivision 3.

**EFFECTIVE DATE.** This section applies to medical assistance and MinnesotaCare coverage effective January 1, 2021.

Sec. 40. Minnesota Statutes 2018, section 256B.0625, subdivision 13f, is amended to read:

Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and recommend drugs which require prior authorization. The Formulary Committee shall establish general criteria to be used for the prior authorization of brand-name drugs for which generically equivalent drugs are available, but the committee is not required to review each brand-name drug for which a generically equivalent drug is available.

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Formulary Committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the Formulary Committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs, information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from the state Medicaid program if such data is available;

(2) the Formulary Committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

(3) the Formulary Committee must hold a public forum and receive public comment for an additional 15 days.

The commissioner must provide a 15-day notice period before implementing the prior authorization.

(c) Except as provided in subdivision 13j, prior authorization shall not be required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:

(1) there is no generically equivalent drug available; and

(2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

(3) the drug is part of the recipient's current course of treatment.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner. Prior authorization shall automatically be granted for 60 days for brand name drugs prescribed for treatment of mental illness within 60 days of when a generically equivalent drug becomes available, provided that the brand name drug was part of the recipient's course of treatment at the time the generically equivalent drug became available.

(d) Prior authorization shall not be required or utilized for any antihemophilic factor drug prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available if the prior authorization is used in conjunction with any supplemental drug rebate program or multistate preferred drug list established or administered by the commissioner.

(e) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates "dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

(f) Notwithstanding this subdivision, the commissioner may automatically require prior authorization, for a period not to exceed 180 days, for any drug that is approved by the United States Food and Drug Administration on or after July 1, 2005. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Formulary Committee shall recommend to the commissioner general criteria to be used for the prior authorization of the drugs, but the committee is not required to review each individual drug. In order to continue prior authorizations for a drug after the 180-day period has expired, the commissioner must follow the provisions of this subdivision.

(g) Any step therapy protocol requirements established by the commissioner must comply with section 62Q.1841.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 41. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 66. **Coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS).** Medical assistance covers treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS). Coverage shall be developed

in collaboration with the Health Services Policy Committee established under subdivision 3c.

Sec. 42. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 67. **Ectodermal dysplasias.** Medical assistance covers the following services for the treatment of ectodermal dysplasias:

(1) scalp hair prosthesis;

(2) breast reconstruction surgery; and

(3) dental services, including bone grafts, dental implants, orthodontia, dental prosthodontics, and dental maintenance.

**EFFECTIVE DATE.** This section is effective January 1, 2020.

Sec. 43. Minnesota Statutes 2018, section 256B.69, is amended by adding a subdivision to read:

Subd. 6e. **Access standards; appointment wait times.** Managed care and county-based purchasing plans must comply with the access standards for emergency care and appointment wait times specified in section 62D.124, subdivisions 1, paragraph (b), and 2, paragraphs (b) and (c).

**EFFECTIVE DATE.** This section is effective for managed care and county-based purchasing contracts entered into on or after January 1, 2020.

Sec. 44. Minnesota Statutes 2018, section 256L.121, subdivision 3, is amended to read:

Subd. 3. **Coordination with state-administered health programs.** The commissioner shall coordinate the administration of the MinnesotaCare program with medical assistance to maximize efficiency and improve the continuity of care. This includes, but is not limited to:

(1) establishing geographic areas for MinnesotaCare that are consistent with the geographic areas of the medical assistance program, within which participating entities may offer health plans;

(2) requiring, as a condition of participation in MinnesotaCare, participating entities to also participate in the medical assistance program;

(3) complying with sections 256B.69, subdivision 3a; 256B.692, subdivision 1; and 256B.694, when contracting with MinnesotaCare participating entities;

(4) providing MinnesotaCare enrollees, to the extent possible, with the option to remain in the same health plan and provider network, if they later become eligible for medical assistance or coverage through MNsure and if, in the case of becoming eligible for medical assistance, the enrollee's MinnesotaCare health plan is also a medical assistance health plan in the enrollee's county of residence; ~~and~~

(5) establishing requirements and criteria for selection that ensure that covered health care services will be coordinated with local public health services, social services, long-term care services, mental health services, and other local services affecting enrollees' health, access, and quality of care~~.~~; and

(6) complying with the appointment wait time standards specified in section 62D.124, subdivisions 1, paragraph (b), and 2, paragraphs (b) and (c).

**EFFECTIVE DATE.** This section is effective for managed care, county-based purchasing, and participating entity contracts entered into on or after January 1, 2020.

Sec. 45. Minnesota Statutes 2018, section 317A.811, is amended by adding a subdivision to read:

Subd. 1a. **Nonprofit health care entity; notice and approval required.** In addition to the requirements of subdivision 1, a nonprofit health care entity as defined in section 317B.01, subdivision 12, is subject to the notice and approval requirements for certain transactions under chapter 317B.

Sec. 46. **[317B.01] NONPROFIT HEALTH CARE ENTITY CONVERSIONS; DEFINITIONS.**

Subdivision 1. **Application.** The definitions in this section apply to this chapter.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of commerce for a nonprofit health care entity that is a nonprofit health service plan corporation operating under chapter 62C, or the commissioner of health for a nonprofit health care entity that is a nonprofit health maintenance organization operating under chapter 62D.

Subd. 3. **Conversion benefit entity.** "Conversion benefit entity" means a foundation, corporation, limited liability company, trust, partnership, or other entity that receives, in connection with a conversion transaction, the value of any public benefit assets, in accordance with section 317B.02, subdivision 7.

Subd. 4. **Conversion transaction or transaction.** "Conversion transaction" or "transaction" means a transaction otherwise permitted by applicable law in which a nonprofit health care entity:

(1) merges, consolidates, converts, or transfers all or a material amount of its assets to any entity except a corporation that is also exempt under United States Code, title 26, section 501(c)(3);

(2) makes a series of separate transfers within a 24-month period that in the aggregate constitute a transfer of all or a material amount of the nonprofit health care entity's assets to any entity except a corporation that is also exempt under United States Code, title 26, section 501(c)(3); or

(3) adds or substitutes one or more members that effectively transfers the control, responsibility for, or governance of the nonprofit health care entity to any entity except a corporation that is also exempt under United States Code, title 26, section 501(c)(3).

Subd. 5. **Corporation.** "Corporation" has the meaning given in section 317A.011, subdivision 6, and also includes a nonprofit limited liability company organized under section 322C.1101.

Subd. 6. **Director.** "Director" has the meaning given in section 317A.011, subdivision 7.

Subd. 7. **Family member.** "Family member" means a spouse, parent, child, spouse of a child, brother, sister, or spouse of a brother or sister.

Subd. 8. **Full and fair value.** "Full and fair value" means the amount that the public benefit assets of the nonprofit health care entity would be worth if the assets were equal to stock in the nonprofit health care entity, if the nonprofit health care entity was a for-profit corporation, and if the nonprofit health care entity had 100 percent of its stock authorized by the corporation and available for purchase without transfer restrictions. The valuation shall consider market value, investment or earning value, net asset value, goodwill, the amount of donations received, and a control premium, if any.

Subd. 9. **Key employee.** "Key employee" means a person, regardless of title, who:

(1) has responsibilities, power, or influence over an organization similar to those of an officer or director;

(2) manages a discrete segment or activity of the organization that represents ten percent or more of the activities, assets, income, or expenses of the organization, as compared to the organization as a whole; or

(3) has or shares authority to control or determine ten percent or more of the organization's capital expenditures, operating budget, or compensation for employees.

Subd. 10. **Material amount.** "Material amount" means the lesser of ten percent of a nonprofit health care entity's total net admitted assets as of December 31 of the preceding year, or $10,000,000.

Subd. 11. **Member.** "Member" has the meaning given in section 317A.011, subdivision 12.

Subd. 12. **Nonprofit health care entity.** "Nonprofit health care entity" means a nonprofit health service plan corporation operating under chapter 62C, a nonprofit health maintenance organization operating under chapter 62D, a corporation that can effectively exercise control over a nonprofit health service plan corporation or a nonprofit health maintenance organization, or any other entity that is effectively controlled by a corporation operating a nonprofit health service plan corporation or a nonprofit health maintenance organization.

Subd. 13. **Officer.** "Officer" has the meaning given in section 317A.011, subdivision 15.

Subd. 14. **Public benefit assets.** "Public benefit assets" means the entirety of a nonprofit health care entity's assets, whether tangible or intangible, including but not limited to its goodwill and anticipated future revenue.

Subd. 15. **Related organization.** "Related organization" has the meaning given in section 317A.011, subdivision 18.

Sec. 47. **[317B.02] NONPROFIT HEALTH CARE ENTITY CONVERSION TRANSACTIONS; REVIEW, NOTICE, APPROVAL.**

Subdivision 1. **Certain conversion transactions prohibited.** A nonprofit health care entity shall not enter into a conversion transaction if a person who has been an officer, director, or key employee of the nonprofit health care entity or of a related organization, or a family member of such a person:

(1) has received or will receive any type of compensation or other financial benefit, directly or indirectly, in connection with the conversion transaction;

(2) has held or will hold, whether guaranteed or contingent, an ownership stake, stock, securities, investment, or other financial interest in an entity to which the nonprofit health care entity transfers public benefit assets in connection with the conversion transaction;

(3) has received or will receive any type of compensation or other financial benefit from an entity to which the nonprofit health care entity transfers public benefit assets in connection with a conversion transaction;

(4) has held or will hold, whether guaranteed or contingent, an ownership stake, stock, securities, investment, or other financial interest in an entity that has or will have a business relationship with an entity to which the nonprofit health care entity transfers public benefit assets in connection with the conversion transaction; or

(5) has received or will receive any type of compensation or other financial benefit from an entity that has or will have a business relationship with an entity to which the nonprofit health care entity transfers public benefit assets in connection with the conversion transaction.

Subd. 2. **Attorney general notice required.** (a) Before entering into a conversion transaction, a nonprofit health care entity must notify the attorney general according to section 317A.811. In addition to the elements listed in section 317A.811, subdivision 1, the notice required by this subdivision must also include an itemization of the nonprofit health care entity's public benefit assets and the valuation the nonprofit health care entity attributes to those assets; a proposed plan for the distribution of the value of those assets to a conversion benefit entity that meets the requirements of subdivision 4; and other information from the nonprofit health care entity or the proposed conversion benefit entity that the attorney general reasonably considers necessary to review the proposed conversion transaction under subdivision 3.

(b) At the time the nonprofit health care entity provides the attorney general with the notice and other information required under this subdivision, the nonprofit health care entity must also provide a copy of the notice and other information required under this subdivision to the commissioner. If the attorney general requests additional information from a nonprofit health care entity in connection with its review of a proposed conversion transaction, the nonprofit health care entity must also provide a copy of this information to the commissioner, at the time this information is provided to the attorney general.

Subd. 3. **Review elements.** (a) The attorney general may approve, conditionally approve, or disapprove a proposed conversion transaction under this section. In determining whether to approve, conditionally approve, or disapprove a proposed transaction, the attorney general, in consultation with the commissioner, shall consider any factors the attorney general considers relevant in evaluating whether the proposed transaction is in the public interest, including whether:

(1) the proposed transaction complies with chapters 317A and 501B and other applicable laws;

(2) the proposed transaction involves or constitutes a breach of charitable trust;

(3) the nonprofit health care entity will receive full and fair value for its public benefit assets;

(4) the value of the public benefit assets to be transferred has been manipulated in a manner that causes or has caused the value of the assets to decrease;

(5) the proceeds of the proposed transaction will be used in a manner consistent with the public benefit for which the assets are held by the nonprofit health care entity;

(6) the proposed transaction will result in a breach of fiduciary duty, as determined by the attorney general, including whether:

(i) conflicts of interest exist related to payments to or benefits conferred upon officers, directors, or key employees of the nonprofit health care entity or a related organization;

(ii) the nonprofit health care entity's directors exercised reasonable care and due diligence in deciding to pursue the transaction, in selecting the entity with which to pursue the transaction, and in negotiating the terms and conditions of the transaction; and

(iii) the nonprofit health care entity's directors considered all reasonably viable alternatives, including any competing offers for its public benefit assets, or alternative transactions;

(7) the transaction will result in financial benefit to a person, including owners, directors, officers, or key employees of the nonprofit health care entity or of the entity to which the nonprofit health care entity proposes to transfer public benefit assets;

(8) the conversion benefit entity meets the requirements in subdivision 4; and

(9) the attorney general and the commissioner have been provided with sufficient information by the nonprofit health care entity to adequately evaluate the proposed transaction and its effects on the public and enrollees, provided the attorney general or commissioner has notified the nonprofit health care entity or the proposed conversion benefit entity if the information provided is insufficient and has provided the nonprofit health care entity or proposed conversion benefit entity with a reasonable opportunity to remedy that insufficiency.

(b) In addition to the elements in paragraph (a), the attorney general shall also consider public comments received under subdivision 5 regarding the proposed conversion transaction

and the proposed transaction's likely effect on the availability, accessibility, and affordability of health care services to the public.

(c) In deciding whether to approve, conditionally approve, or disapprove a transaction, the attorney general must consult with the commissioner.

Subd. 4. **Conversion benefit entity requirements.** (a) A conversion benefit entity shall:

(1) be an existing or new, domestic, nonprofit corporation operating under chapter 317A and exempt under United States Code, title 26, section 501(c)(3);

(2) have in place procedures and policies to prohibit conflicts of interest, including but not limited to conflicts of interest relating to any grant-making activities that may benefit:

(i) the directors, officers, or key employees of the conversion benefit entity;

(ii) any entity to which the nonprofit health care entity transfers public benefit assets in connection with a conversion transaction; or

(iii) any directors, officers, or key employees of an entity to which the nonprofit health care entity transfers public benefit assets in connection with a conversion transaction;

(3) operate to benefit the health of the people of this state; and

(4) have in place procedures and policies that prohibit:

(i) an officer, director, or key employee of the nonprofit health care entity from serving as an officer, director, or key employee of the conversion benefit entity for the five-year period following the conversion transaction;

(ii) an officer, director, or key employee of the nonprofit health care entity or of the conversion benefit entity from directly or indirectly benefiting from the conversion transaction; and

(iii) elected or appointed public officials from serving as an officer, director, or key employee of the conversion benefit entity.

(b) A conversion benefit entity shall not make grants or payments or otherwise provide financial benefit to an entity to which a nonprofit health care entity transfers public benefit assets as part of a conversion transaction, or to a related organization of the entity to which the nonprofit health care entity transfers public benefit assets as part of a conversion transaction.

(c) No person who has been an officer, director, or key employee of an entity that has received public benefit assets in connection with a conversion transaction may serve as an officer, director, or key employee of the conversion benefit entity.

(d) The attorney general must review and approve the governance structure of a conversion benefit entity before the conversion benefit entity receives the value of public benefit assets from a nonprofit health care entity. In order to be approved by the attorney general under this paragraph, the conversion benefit entity's governance must be broadly based in the community served by the nonprofit health care entity and must be independent of the entity to which the nonprofit health care entity transfers public benefit assets as part of the conversion transaction. As part of the review of the conversion benefit entity's governance, the attorney general shall hold a public hearing. If the attorney general finds it necessary, a portion of the value of the public benefit assets shall be used to develop a community-based plan for use by the conversion benefit entity.

(e) The attorney general shall establish a community advisory committee for a conversion benefit entity receiving the value of public benefit assets. The members of the community advisory committee must be selected to represent the diversity of the community previously served by the nonprofit health care entity. The community advisory committee shall:

(1) provide a slate of three nominees for each vacancy on the governing board of the conversion benefit entity, from which the remaining board members shall select new members to the board;

(2) provide the governing board with guidance on the health needs of the community previously served by the nonprofit health care entity; and

(3) promote dialogue and information sharing between the conversion benefit entity and the community previously served by the nonprofit health care entity.

Subd. 5. **Hearing; public comment; maintenance of record.** (a) Before issuing a decision under subdivision 6, the attorney general shall hold one or more hearings and solicit public comments regarding the proposed conversion transaction. No later than 45 days after the attorney general receives notice of a proposed conversion transaction, the attorney general shall hold at least one public hearing in the area served by the nonprofit health care entity, and shall hold as many hearings as necessary in various parts of the state to ensure that each community in the nonprofit health care entity's service area has an opportunity to provide comments on the conversion transaction. Any person may appear and speak at the hearing, file written comments, or file exhibits for the hearing. At least 14 days before the hearing, the attorney general shall provide written notice of the hearing through posting on

the attorney general's website, publication in one or more newspapers of general circulation, and notice by means of a public listserv or through other means to all persons who request notice from the attorney general of such hearings. A public hearing is not required if the waiting period under subdivision 6 is waived or is shorter than 45 days in duration. The attorney general may also solicit public comments through other means.

(b) The attorney general shall develop and maintain a summary of written and oral public comments made at a hearing and otherwise received by the attorney general, shall record all questions posed during the public hearing or received by the attorney general, and shall require answers from the appropriate parties. The summary materials, questions, and answers shall be maintained on the attorney general's website, and the attorney general must provide a copy of these materials at no cost to any person who requests them.

Subd. 6. **Approval required; period for approval or disapproval; extension.** (a) Notwithstanding the time periods in section 15.99 or 317A.811, a nonprofit health care entity shall not enter into a conversion transaction until:

(1) 150 days after the entity has given written notice to the attorney general, unless the attorney general waives all or a part of the waiting period. The attorney general shall establish guidelines for when the attorney general may waive all or part of the waiting period, and must provide public notice if the attorney general waives all or part of the waiting period; and

(2) the nonprofit health care entity obtains approval of the transaction from the attorney general, or obtains conditional approval from the attorney general and satisfies the required conditions.

(b) During the waiting period, the attorney general shall decide whether to approve, conditionally approve, or disapprove the conversion transaction and shall notify the nonprofit health care entity in writing of the attorney general's decision. If the transaction is disapproved, the notice must include the reasons for the decision. If the transaction is conditionally approved, the notice must specify the conditions that must be met and the reasons for these conditions. The attorney general may extend the waiting period for an additional 90 days by notifying the nonprofit health care entity of the extension in writing.

(c) The time periods under this subdivision shall be suspended while a request from the attorney general for additional information is outstanding.

Subd. 7. **Transfer of value of assets required.** If a proposed conversion transaction is approved or conditionally approved by the attorney general, the nonprofit health care entity

shall transfer the entirety of the full and fair value of its public benefit assets to one or more conversion benefit entities as part of the transaction.

Subd. 8. **Assessment of costs.** (a) The nonprofit health care entity must reimburse the attorney general or a state agency for all reasonable and actual costs incurred by the attorney general or the state agency in reviewing the proposed conversion transaction and in exercising enforcement remedies under this section. Costs incurred may include attorney fees at the rate at which the attorney general bills state agencies; costs for retaining actuarial, valuation, or other experts and consultants; and administrative costs. In order to receive reimbursement under this subdivision, the attorney general or state agency must provide the nonprofit health care entity with a statement of costs incurred.

(b) The nonprofit health care entity must remit the total amount listed on the statement to the attorney general or state agency within 30 days after the statement date, unless the entity disputes some or all of the submitted costs. The nonprofit health care entity may dispute the submitted costs by bringing an action in district court to have the court determine the amount of the reasonable and actual costs that must be remitted.

(c) Money remitted to the attorney general or state agency under this subdivision shall be deposited in the general fund in the state treasury and is appropriated to the attorney general or state agency, as applicable, to reimburse the attorney general or state agency for costs paid or incurred under this section.

Subd. 9. **Challenge to disapproval or conditional approval.** If the attorney general disapproves or conditionally approves a conversion transaction, a nonprofit health care entity may bring an action in district court to challenge the disapproval, or any condition of a conditional approval, as applicable. To prevail in such an action, the nonprofit health care entity must clearly establish that the disapproval, or each condition being challenged, as applicable, is arbitrary and capricious and unnecessary to protect the public interest.

Subd. 10. **Penalties; remedies.** The attorney general is authorized to bring an action to unwind a conversion transaction entered into in violation of this section and to recover the amount of any financial benefit received or held in violation of subdivision 1. In addition to this recovery, the officers, directors, and key employees of each entity that is a party to, and who materially participated in, the transaction entered into in violation of this section, may be subject to a civil penalty of up to the greater of the entirety of any financial benefit each officer, director, or key employee derived from the transaction or $1,000,000, as determined by the court. The attorney general is authorized to enforce this section under section 8.31.

Subd. 11. **Relation to other law.** (a) This section is in addition to, and does not affect or limit any power, remedy, or responsibility of a health maintenance organization, a service plan corporation, a conversion benefit entity, the attorney general, the commissioner of commerce, or commissioner of health under chapter 62C, 62D, 317A, or 501B, or other law.

(b) Nothing in this section authorizes a nonprofit health care entity to enter into a conversion transaction not otherwise permitted under chapter 317A or 501B or other law.

Sec. 48. Laws 2017, First Special Session chapter 6, article 5, section 11, is amended to read:

Sec. 11. **MORATORIUM ON CONVERSION TRANSACTIONS.**

(a) Notwithstanding Laws 2017, chapter 2, article 2, a nonprofit ~~health~~ service plan corporation operating under Minnesota Statutes, chapter 62C~~, or~~; a nonprofit health maintenance organization operating under Minnesota Statutes, chapter 62D, as of January 1, 2017~~,~~; or a direct or indirect parent, subsidiary, or other affiliate of such an entity, may only merge or consolidate with; ~~or~~ convert~~,~~; or transfer, as part of a single transaction or a series of transactions within a 24-month period, all or a ~~substantial portion~~ material amount of its assets to an entity that is a corporation organized under Minnesota Statutes, chapter 317A. For purposes of this section, "material amount" means the lesser of ten percent of such an entity's total net admitted assets as of December 31 of the preceding year, or $10,000,000.

(b) Paragraph (a) does not apply if the nonprofit service plan corporation or nonprofit health maintenance organization files an intent to dissolve due to insolvency of the corporation in accordance with Minnesota Statutes, chapter 317A, or insolvency proceedings are commenced under Minnesota Statutes, chapter 60B.

(c) Nothing in this section shall be construed to authorize a nonprofit health maintenance organization or a nonprofit ~~health~~ service plan corporation to engage in any transaction or activities not otherwise permitted under state law.

(d) This section expires July 1, ~~2019~~ 2029.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 49. **FINDINGS.**

The Legislature of the state of Minnesota finds and declares that:

(1) nonprofit health care entities hold their assets in trust, and those assets are irrevocably dedicated, as a condition of their tax-exempt status, to the specific charitable purpose set forth in the articles of incorporation of the entities;

(2) the public is the beneficiary of that trust;

(3) nonprofit health care entities have a substantial and beneficial effect on the quality of life of the people of Minnesota;

(4) transfers of assets by nonprofit health care entities to for-profit entities directly affect the charitable uses of those assets and may adversely affect the public as the beneficiary of the charitable assets;

(5) it is in the best interest of the public to ensure that the public interest is fully protected whenever the assets or operations of a nonprofit health care entity are transferred, directly or indirectly, from a charitable trust to a for-profit or mutual benefit entity; and

(6) the attorney general's approval of any transfers of assets or operations by a nonprofit health care entity is necessary to ensure the protection of these trusts.

Sec. 50. **REPORT; DENIALS OF COVERAGE FOR TREATMENT FOR PEDIATRIC AUTOIMMUNE NEUROPSYCHIATRIC DISORDERS ASSOCIATED WITH STREPTOCOCCAL INFECTIONS (PANDAS) AND PEDIATRIC ACUTE-ONSET NEUROPSYCHIATRIC SYNDROME (PANS).**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Health carrier" has the meaning given in Minnesota Statutes, section 62A.011, subdivision 2.

(c) "Health plan" has the meaning given in Minnesota Statutes, section 62A.011, subdivision 3.

(d) "Pediatric acute-onset neuropsychiatric syndrome" and "pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections" have the meanings given in Minnesota Statutes, section 62A.3097, subdivision 1.

Subd. 2. **Report required.** (a) A health carrier that offers a health plan providing coverage to Minnesota residents must report the following to the commissioner of health by October 1, 2019:

(1) the number of times the health carrier has denied coverage for treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) or for treatment for pediatric acute-onset neuropsychiatric syndrome (PANS); and

(2) for each denial of coverage, the specific treatment for which coverage was denied.

(b) The commissioner of health must compile the information submitted under this subdivision into a single report and must post that report to the department's website on or before November 1, 2019. The posted report must identify each reporting health carrier and must specify, for each carrier, the number of coverage denials for each specific treatment.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 51. **COVERAGE FOR ECTODERMAL DYSPLASIAS AND PANDAS OR PANS.**

A health plan's coverage as of January 1, 2019, must be used by the health carrier as the basis for determining whether coverage would not have been provided by the health carrier pursuant to Minnesota Statutes, section 62A.25, subdivision 2, paragraph (d); 62A.28, subdivision 2, paragraph (c); 62A.3096, subdivision 4; or 62A.3097, subdivision 4. Treatments and services covered by the health plan as of January 1, 2019, are not eligible for reimbursement by the commissioner of commerce.

Sec. 52. **REVISOR INSTRUCTION.**

The revisor of statutes shall codify Laws 2017, First Special Session chapter 6, article 5, section 11, as amended by this act, in Minnesota Statutes, chapter 62D.

Sec. 53. **REPEALER.**

Minnesota Statutes 2018, section 62A.021, subdivisions 1 and 3, are repealed effective the day following final enactment.

## ARTICLE 14
## RESIDENT RIGHTS AND CONSUMER PROTECTIONS

Section 1. **[144.6512] RETALIATION IN NURSING HOMES PROHIBITED.**

Subdivision 1. **Definitions.** For the purposes of this section:

(1) "nursing home" means a facility licensed as a nursing home under chapter 144A; and

(2) "resident" means a person residing in a nursing home.

Subd. 2. **Retaliation prohibited.** A nursing home or agent of the nursing home may not retaliate against a resident or employee if the resident, employee, or any person acting on behalf of the resident:

(1) files a complaint or grievance, makes an inquiry, or asserts any right;

(2) indicates an intention to file a complaint or grievance, make an inquiry, or assert any right;

(3) files or indicates an intention to file a maltreatment report, whether mandatory or voluntary, under section 626.557;

(4) seeks assistance from or reports a reasonable suspicion of a crime or systemic problems or concerns to the administrator or manager of the nursing home, the Office of Ombudsman for Long-Term Care, a regulatory or other government agency, or a legal or advocacy organization;

(5) advocates or seeks advocacy assistance for necessary or improved care or services or enforcement of rights under this section or other law;

(6) takes or indicates an intention to take civil action;

(7) participates or indicates an intention to participate in any investigation or administrative or judicial proceeding;

(8) contracts or indicates an intention to contract to receive services from a service provider of the resident's choice other than the nursing home; or

(9) places or indicates an intention to place a camera or electronic monitoring device in the resident's private space as provided under section 144J.05.

Subd. 3. **Retaliation against a resident.** For purposes of this section, to retaliate against a resident includes but is not limited to any of the following actions taken or threatened by a nursing home or an agent of the nursing home against a resident, or any person with a familial, personal, legal, or professional relationship with the resident:

(1) the discharge, eviction, transfer, or termination of services;

(2) the imposition of discipline, punishment, or a sanction or penalty;

(3) any form of discrimination;

(4) restriction or prohibition of access:

(i) of the resident to the nursing home or visitors; or

(ii) to the resident by a family member or a person with a personal, legal, or professional relationship with the resident;

(5) the imposition of involuntary seclusion or withholding food, care, or services;

(6) restriction of any of the rights granted to residents under state or federal law;

(7) restriction or reduction of access to or use of amenities, care, services, privileges, or living arrangements;

(8) an arbitrary increase in charges or fees;

(9) removing, tampering with, or deprivation of technology, communication, or electronic monitoring devices; or

(10) any oral or written communication of false information about a person advocating on behalf of the resident.

Subd. 4. **Retaliation against an employee.** For purposes of this section, to retaliate against an employee includes but is not limited to any of the following actions taken or threatened by the nursing home or an agent of the nursing home against an employee:

(1) discharge or transfer;

(2) demotion or refusal to promote;

(3) reduction in compensation, benefits, or privileges;

(4) the unwarranted imposition of discipline, punishment, or a sanction or penalty; or

(5) any form of discrimination.

Subd. 5. **Rebuttable presumption of retaliation.** (a) Except as provided in paragraphs (b), (c), and (d), there is a rebuttable presumption that any action described in subdivision 3 or 4 and taken within 90 days of an initial action described in subdivision 2 is retaliatory.

(b) The presumption does not apply to actions described in subdivision 3, clause (4), if a good faith report of maltreatment pursuant to section 626.557 is made by the nursing home or agent of the nursing home against the visitor, family member, or other person with a personal, legal, or professional relationship that is subject to the restriction or prohibition of access.

(c) The presumption does not apply to any oral or written communication described in subdivision 3, clause (10), that is associated with a good faith report of maltreatment pursuant to section 626.557 made by the nursing home or agent of the nursing home against the person advocating on behalf of the resident.

(d) The presumption does not apply to a termination of a contract of admission, as that term is defined under section 144.6501, subdivision 1, for a reason permitted under state or federal law.

Subd. 6. **Remedy.** A resident who meets the criteria under section 325F.71, subdivision 1, has a cause of action under section 325F.71, subdivision 4, for the violation of this section, unless the resident otherwise has a cause of action under section 626.557, subdivision 17.

**EFFECTIVE DATE.** This section is effective August 1, 2019.

Sec. 2. **[144G.07] RETALIATION PROHIBITED.**

Subdivision 1. **Definitions.** For the purposes of this section and section 144G.08:

(1) "facility" means a housing with services establishment registered under section 144D.02 and operating under title protection under this chapter; and

(2) "resident" means a resident of a facility.

Subd. 2. **Retaliation prohibited.** A facility or agent of the facility may not retaliate against a resident or employee if the resident, employee, or any person on behalf of the resident:

(1) files a complaint or grievance, makes an inquiry, or asserts any right;

(2) indicates an intention to file a complaint or grievance, make an inquiry, or assert any right;

(3) files or indicates an intention to file a maltreatment report, whether mandatory or voluntary, under section 626.557;

(4) seeks assistance from or reports a reasonable suspicion of a crime or systemic problems or concerns to the administrator or manager of the facility, the Office of Ombudsman for Long-Term Care, a regulatory or other government agency, or a legal or advocacy organization;

(5) advocates or seeks advocacy assistance for necessary or improved care or services or enforcement of rights under this section or other law;

(6) takes or indicates an intention to take civil action;

(7) participates or indicates an intention to participate in any investigation or administrative or judicial proceeding;

(8) contracts or indicates an intention to contract to receive services from a service provider of the resident's choice other than the facility; or

(9) places or indicates an intention to place a camera or electronic monitoring device in the resident's private space as provided under section 144J.05.

Subd. 3. **Retaliation against a resident.** For purposes of this section, to retaliate against a resident includes but is not limited to any of the following actions taken or threatened by a facility or an agent of the facility against a resident, or any person with a familial, personal, legal, or professional relationship with the resident:

(1) the discharge, eviction, transfer, or termination of services;

(2) the imposition of discipline, punishment, or a sanction or penalty;

(3) any form of discrimination;

(4) restriction or prohibition of access:

(i) of the resident to the facility or visitors; or

(ii) to the resident by a family member or a person with a personal, legal, or professional relationship with the resident;

(5) the imposition of involuntary seclusion or withholding food, care, or services;

(6) restriction of any of the rights granted to residents under state or federal law;

(7) restriction or reduction of access to or use of amenities, care, services, privileges, or living arrangements;

(8) an arbitrary increase in charges or fees;

(9) removing, tampering with, or deprivation of technology, communication, or electronic monitoring devices; or

(10) any oral or written communication of false information about a person advocating on behalf of the resident.

Subd. 4. **Retaliation against an employee.** For purposes of this section, to retaliate against an employee includes but is not limited to any of the following actions taken or threatened by the facility or an agent of the facility against an employee:

(1) discharge or transfer;

(2) demotion or refusal to promote;

(3) reduction in compensation, benefits, or privileges;

(4) the unwarranted imposition of discipline, punishment, or a sanction or penalty; or

(5) any form of discrimination.

Subd. 5. **Rebuttable presumption of retaliation.** (a) Except as provided in paragraphs (b), (c), and (d), there is a rebuttable presumption that any action described in subdivision 3 or 4 and taken within 90 days of an initial action described in subdivision 2 is retaliatory.

(b) The presumption does not apply to actions described in subdivision 3, clause (4), if a good faith report of maltreatment pursuant to section 626.557 is made by the facility or agent of the facility against the visitor, family member, or other person with a personal, legal, or professional relationship that is subject to the restriction or prohibition of access.

(c) The presumption does not apply to any oral or written communication described in subdivision 3, clause (10), that is associated with a good faith report of maltreatment pursuant to section 626.557 made by the facility or agent of the facility against the person advocating on behalf of the resident.

(d) The presumption does not apply to a termination of a contract of admission, as that term is defined under section 144.6501, subdivision 1, for a reason permitted under state or federal law.

Subd. 6. **Remedy.** A resident who meets the criteria under section 325F.71, subdivision 1, has a cause of action under section 325F.71, subdivision 4, for the violation of this section, unless the resident otherwise has a cause of action under section 626.557, subdivision 17.

**EFFECTIVE DATE.** This section is effective August 1, 2019, and expires July 31, 2021.

Sec. 3. **[144G.08] DECEPTIVE MARKETING AND BUSINESS PRACTICES PROHIBITED.**

Subdivision 1. **Prohibitions.** (a) No employee or agent of any facility may make any false, fraudulent, deceptive, or misleading statements or representations or material omissions in marketing, advertising, or any other description or representation of care or services.

(b) No housing with services contract as required under section 144D.04, subdivision 1, may include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.

(c) No facility may advertise or represent that the facility has a dementia care unit without complying with disclosure requirements under section 325F.72 and any training requirements required by law or rule.

Subd. 2. **Remedies.** (a) A violation of this section constitutes a violation of section 325F.69, subdivision 1. The attorney general or a county attorney may enforce this section using the remedies in section 325F.70.

(b) A resident who meets the criteria under section 325F.71, subdivision 1, has a cause of action under section 325F.71, subdivision 4, for the violation of this section, unless the resident otherwise has a cause of action under section 626.557, subdivision 17.

**EFFECTIVE DATE.** This section is effective August 1, 2019, and expires July 31, 2021.

Sec. 4. **[144J.01] DEFINITIONS.**

Subdivision 1. **Applicability.** For the purposes of this chapter, the following terms have the meanings given them unless the context clearly indicates otherwise.

Subd. 2. **Assisted living contract.** "Assisted living contract" means the legal agreement between a resident and an assisted living facility for housing and assisted living services.

Subd. 3. **Assisted living facility.** "Assisted living facility" has the meaning given in section 144I.01, subdivision 6.

Subd. 4. **Assisted living facility with dementia care.** "Assisted living facility with dementia care" has the meaning given in section 144I.01, subdivision 8.

Subd. 5. **Assisted living services.** "Assisted living services" has the meaning given in section 144I.01, subdivision 7.

Subd. 6. **Attorney-in-fact.** "Attorney-in-fact" means a person designated by a principal to exercise the powers granted by a written and valid power of attorney under chapter 523.

Subd. 7. **Conservator.** "Conservator" means a court-appointed conservator acting in accordance with the powers granted to the conservator under chapter 524.

Subd. 8. **Designated representative.** "Designated representative" means a person designated in writing by the resident in an assisted living contract and identified in the resident's records on file with the assisted living facility.

Subd. 9. **Facility.** "Facility" means an assisted living facility.

Subd. 10. **Guardian.** "Guardian" means a court-appointed guardian acting in accordance with the powers granted to the guardian under chapter 524.

Subd. 11. **Health care agent.** "Health care agent" has the meaning given in section 145C.01, subdivision 2.

Subd. 12. **Legal representative.** "Legal representative" means one of the following in the order of priority listed, to the extent the person may reasonably be identified and located:

(1) a guardian;

(2) a conservator;

(3) a health care agent; or

(4) an attorney-in-fact.

Subd. 13. **Licensed health care professional.** "Licensed health care professional" means:

(1) a physician licensed under chapter 147;

(2) an advanced practice registered nurse, as that term is defined in section 148.171, subdivision 3;

(3) a licensed practical nurse, as that term is defined in section 148.171, subdivision 8; or

(4) a registered nurse, as that term is defined in section 148.171, subdivision 20.

Subd. 14. **Resident.** "Resident" means a person living in an assisted living facility.

Subd. 15. **Resident record.** "Resident record" has the meaning given in section 144I.01, subdivision 53.

Subd. 16. **Service plan.** "Service plan" has the meaning given in section 144I.01, subdivision 57.

**EFFECTIVE DATE.** This section is effective August 1, 2021.

Sec. 5. **[144J.02] RESIDENT RIGHTS.**

Subdivision 1. **Applicability.** This section applies to assisted living facility residents.

Subd. 2. **Legislative intent.** The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility.

Subd. 3. **Information about rights and facility policies.** (a) Before receiving services, residents have the right to be informed by the facility of the rights granted under this section. The information must be in plain language and in terms residents can understand. The facility must make reasonable accommodations for residents who have communication disabilities and those who speak a language other than English.

(b) Every facility must:

(1) indicate what recourse residents have if their rights are violated; and

(2) provide the information required under section 144J.10.

(c) Upon request, residents and their legal representatives and designated representatives have the right to copies of current facility policies and inspection findings of state and local health authorities, and to receive further explanation of the rights provided under this section, consistent with chapter 13 and section 626.557.

Subd. 4. **Courteous treatment.** Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect.

Subd. 5. **Appropriate care and services.** (a) Residents have the right to care and services that are appropriate based on the resident's needs and according to an up-to-date service plan. All service plans must be designed to enable residents to achieve their highest level of emotional, psychological, physical, medical, and functional well-being and safety.

(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.

Subd. 6. **Participation in care and service planning.** Residents have the right to actively participate in the planning, modification, and evaluation of their care and services. This right includes:

(1) the opportunity to discuss care, services, treatment, and alternatives with the appropriate caregivers;

(2) the opportunity to request and participate in formal care conferences;

(3) the right to include a family member or the resident's health care agent and designated representative, or both; and

(4) the right to be told in advance of, and take an active part in decisions regarding, any recommended changes in the service plan.

Subd. 7. **Information about individuals providing services.** Before receiving services, residents have the right to be told the type and disciplines of staff who will be providing the services, the frequency of visits proposed to be furnished, and other choices that are available for addressing the resident's needs.

Subd. 8. **Information about health care treatment.** Where applicable, residents have the right to be given by their attending physician complete and current information concerning their diagnosis, cognitive functioning level, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information must be in terms and language the residents can reasonably be expected to understand. This information must include the likely medical or major psychological results of the treatment and its alternatives.

Subd. 9. **Information about other providers and services.** (a) Residents have the right to be informed by the assisted living facility, prior to executing an assisted living contract, that other public and private services may be available and the resident has the right to purchase, contract for, or obtain services from a provider other than the assisted living facility or related assisted living services provider.

(b) Assisted living facilities must make every effort to assist residents in obtaining information regarding whether Medicare, medical assistance, or another public program will pay for any of the services.

Subd. 10. **Information about charges.** Before services are initiated, residents have the right to be notified:

(1) of all charges for services;

(2) whether payment may be expected from health insurance, public programs, or other sources, if known, and the amount of such payments; and

(3) what charges the resident may be responsible for paying.

Subd. 11. **Refusal of care or services.** (a) Residents have the right to refuse care or services.

(b) A provider must document in the resident's record that the provider informed a resident who refuses care, services, treatment, medication, or dietary restrictions of the likely medical, health-related, or psychological consequences of the refusal.

(c) In cases where a resident lacks capacity but has not been adjudicated incompetent, or when legal requirements limit the right to refuse medical treatment, the conditions and circumstances must be fully documented by the attending physician in the resident's record.

Subd. 12. **Freedom from maltreatment.** Residents have the right to be free from maltreatment. For the purposes of this subdivision, "maltreatment" means conduct described in section 626.5572, subdivision 15, and includes the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress.

Subd. 13. **Personal and treatment privacy.** (a) Residents have the right to every consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable.

(b) Residents have the right to respect and privacy regarding the resident's health care and personal care program. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance.

Subd. 14. **Communication privacy.** (a) Residents have the right to communicate privately with persons of their choice. Assisted living facilities that are unable to provide a private area for communication must make reasonable arrangements to accommodate the privacy of residents' communications.

(b) Personal mail must be sent by the assisted living facility without interference and received unopened unless medically or programmatically contraindicated and documented by a licensed health care professional listed in the resident's record.

(c) Residents must be provided access to a telephone to make and receive calls.

Subd. 15. **Confidentiality of records.** (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party.

(b) Residents have the right to access their own records and written information from those records in accordance with sections 144.291 to 144.298.

Subd. 16. **Grievances and inquiries.** (a) Residents have the right to make and receive a timely response to a complaint or inquiry, without limitation. Residents have the right to know and every facility must provide the name and contact information of the person representing the facility who is designated to handle and resolve complaints and inquiries.

(b) A facility must promptly investigate, make a good faith attempt to resolve, and provide a timely response to the complaint or inquiry.

(c) Residents have the right to recommend changes in policies and services to staff and managerial officials, as that term is defined in section 144I.01, subdivision 31.

Subd. 17. **Visitors and social participation.** (a) Residents have the right to meet with or receive visits at any time by the resident's family, guardian, conservator, health care agent, attorney, advocate, or religious or social work counselor, or any person of the resident's choosing.

(b) Residents have the right to participate in commercial, religious, social, community, and political activities without interference and at their discretion if the activities do not infringe on the right to privacy of other residents.

Subd. 18. **Access to counsel and advocacy services.** Notwithstanding subdivision 15, residents have the right to the immediate access by:

(1) the resident's legal counsel;

(2) any representative of the protection and advocacy system designated by the state under Code of Federal Regulations, title 45, section 1326.21; or

(3) any representative of the Office of Ombudsman for Long-Term Care.

Subd. 19. **Right to come and go freely.** Residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan.

Subd. 20. **Access to technology.** Residents have the right to access Internet service at their expense, unless offered by the facility.

Subd. 21. **Resident councils.** Residents have the right to organize and participate in resident councils. The facility must provide a resident council with space and privacy for meetings, where doing so is reasonably achievable. Staff, visitors, or other guests may attend resident council meetings only at the council's invitation. The facility must provide a designated staff person who is approved by the resident council and the facility to be responsible for providing assistance and responding to written requests that result from meetings. The facility must consider the views of the resident council and must act promptly upon the grievances and recommendations of the council, but a facility is not required to implement as recommended every request of the council. The facility shall, with the approval of the resident council, take reasonably achievable steps to make residents aware of upcoming meetings in a timely manner.

Subd. 22. **Family councils.** Residents have the right to participate in family councils formed by families or residents. The facility must provide a family council with space and privacy for meetings, where doing so is reasonably achievable. The facility must provide a designated staff person who is approved by the family council and the facility to be

responsible for providing assistance and responding to written requests that result from meetings. The facility must consider the views of the family council and must act promptly upon the grievances and recommendations of the council, but a facility is not required to implement as recommended every request of the council. The facility shall, with the approval of the family council, take reasonably achievable steps to make residents and family members aware of upcoming meetings in a timely manner.

**EFFECTIVE DATE.** This section is effective August 1, 2019.

Sec. 6. **[144J.03] RETALIATION PROHIBITED.**

Subdivision 1. **Retaliation prohibited.** A facility or agent of a facility may not retaliate against a resident or employee if the resident, employee, or any person acting on behalf of the resident:

(1) files a complaint or grievance, makes an inquiry, or asserts any right;

(2) indicates an intention to file a complaint or grievance, make an inquiry, or assert any right;

(3) files or indicates an intention to file a maltreatment report, whether mandatory or voluntary, under section 626.557;

(4) seeks assistance from or reports a reasonable suspicion of a crime or systemic problems or concerns to the administrator or manager of the facility, the Office of Ombudsman for Long-Term Care, a regulatory or other government agency, or a legal or advocacy organization;

(5) advocates or seeks advocacy assistance for necessary or improved care or services or enforcement of rights under this section or other law;

(6) takes or indicates an intention to take civil action;

(7) participates or indicates an intention to participate in any investigation or administrative or judicial proceeding;

(8) contracts or indicates an intention to contract to receive services from a service provider of the resident's choice other than the facility; or

(9) places or indicates an intention to place a camera or electronic monitoring device in the resident's private space as provided under section 144J.05.

Subd. 2. **Retaliation against a resident.** For purposes of this section, to retaliate against a resident includes but is not limited to any of the following actions taken or threatened by

a facility or an agent of the facility against a resident, or any person with a familial, personal, legal, or professional relationship with the resident:

(1) the discharge, eviction, transfer, or termination of services;

(2) the imposition of discipline, punishment, or a sanction or penalty;

(3) any form of discrimination;

(4) restriction or prohibition of access:

(i) of the resident to the facility or visitors; or

(ii) to the resident by a family member or a person with a personal, legal, or professional relationship with the resident;

(5) the imposition of involuntary seclusion or withholding food, care, or services;

(6) restriction of any of the rights granted to residents under state or federal law;

(7) restriction or reduction of access to or use of amenities, care, services, privileges, or living arrangements;

(8) an arbitrary increase in charges or fees;

(9) removing, tampering with, or deprivation of technology, communication, or electronic monitoring devices; or

(10) any oral or written communication of false information about a person advocating on behalf of the resident.

Subd. 3. **Retaliation against an employee.** For purposes of this section, to retaliate against an employee includes but is not limited to any of the following actions taken or threatened by the facility or an agent of the facility against an employee:

(1) discharge or transfer;

(2) demotion or refusal to promote;

(3) reduction in compensation, benefits, or privileges;

(4) the unwarranted imposition of discipline, punishment, or a sanction or penalty; or

(5) any form of discrimination.

Subd. 4. **Rebuttable presumption of retaliation.** (a) Except as provided in paragraphs (b), (c), and (d), there is a rebuttable presumption that any action described in subdivision 2 or 3 and taken within 90 days of an initial action described in subdivision 1 is retaliatory.

(b) The presumption does not apply to actions described in subdivision 2, clause (4), if a good faith report of maltreatment pursuant to section 626.557 is made by the facility or agent of the facility against the visitor, family member, or other person with a personal, legal, or professional relationship that is subject to the restriction or prohibition of access.

(c) The presumption does not apply to any oral or written communication described in subdivision 2, clause (10), that is associated with a good faith report of maltreatment pursuant to section 626.557 made by the facility or agent of the facility against the person advocating on behalf of the resident.

(d) The presumption does not apply to a discharge, eviction, transfer, or termination of services that occurs for a reason permitted under section 144J.08, subdivision 3 or 6, provided the assisted living facility has complied with the applicable requirements in sections 144J.08 and 144.10.

Subd. 5. **Other laws.** Nothing in this section affects the rights available to a resident under section 626.557.

**EFFECTIVE DATE.** This section is effective August 1, 2021.

Sec. 7. **[144J.04] DECEPTIVE MARKETING AND BUSINESS PRACTICES PROHIBITED.**

(a) No employee or agent of any facility may make any false, fraudulent, deceptive, or misleading statements or representations or material omissions in marketing, advertising, or any other description or representation of care or services.

(b) No assisted living contract may include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.

(c) No facility may advertise or represent that it is licensed as an assisted living facility with dementia care without complying with disclosure requirements under section 325F.72 and any training requirements required under chapter 144I or in rule.

(d) A violation of this section constitutes a violation of section 325F.69, subdivision 1. The attorney general or a county attorney may enforce this section using the remedies in section 325F.70.

**EFFECTIVE DATE.** This section is effective August 1, 2021.

Sec. 8. **[144J.05] ELECTRONIC MONITORING IN CERTAIN FACILITIES.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Commissioner" means the commissioner of health.

(c) "Department" means the Department of Health.

(d) "Electronic monitoring" means the placement and use of an electronic monitoring device by a resident in the resident's room or private living unit in accordance with this section.

(e) "Electronic monitoring device" means a camera or other device that captures, records, or broadcasts audio, video, or both, that is placed in a resident's room or private living unit and is used to monitor the resident or activities in the room or private living unit.

(f) "Facility" means a facility that is:

(1) licensed as a nursing home under chapter 144A;

(2) licensed as a boarding care home under sections 144.50 to 144.56;

(3) until August 1, 2021, a housing with services establishment registered under chapter 144D that is either subject to chapter 144G or has a disclosed special unit under section 325F.72; or

(4) on or after August 1, 2021, an assisted living facility.

(g) "Resident" means a person 18 years of age or older residing in a facility.

(h) "Resident representative" means one of the following in the order of priority listed, to the extent the person may reasonably be identified and located:

(1) a court-appointed guardian;

(2) a health care agent as defined in section 145C.01, subdivision 2; or

(3) a person who is not an agent of a facility or of a home care provider designated in writing by the resident and maintained in the resident's records on file with the facility or with the resident's executed housing with services contract or nursing home contract.

Subd. 2. **Electronic monitoring authorized.** (a) A resident or a resident representative may conduct electronic monitoring of the resident's room or private living unit through the use of electronic monitoring devices placed in the resident's room or private living unit as provided in this section.

(b) Nothing in this section precludes the use of electronic monitoring of health care allowed under other law.

(c) Electronic monitoring authorized under this section is not a covered service under home and community-based waivers under sections 256B.0913, 256B.0915, 256B.092, and 256B.49.

(d) This section does not apply to monitoring technology authorized as a home and community-based service under section 256B.0913, 256B.0915, 256B.092, or 256B.49.

Subd. 3. **Consent to electronic monitoring.** (a) Except as otherwise provided in this subdivision, a resident must consent to electronic monitoring in the resident's room or private living unit in writing on a notification and consent form. If the resident has not affirmatively objected to electronic monitoring and the resident's medical professional determines that the resident currently lacks the ability to understand and appreciate the nature and consequences of electronic monitoring, the resident representative may consent on behalf of the resident. For purposes of this subdivision, a resident affirmatively objects when the resident orally, visually, or through the use of auxiliary aids or services declines electronic monitoring. The resident's response must be documented on the notification and consent form.

(b) Prior to a resident representative consenting on behalf of a resident, the resident must be asked if the resident wants electronic monitoring to be conducted. The resident representative must explain to the resident:

(1) the type of electronic monitoring device to be used;

(2) the standard conditions that may be placed on the electronic monitoring device's use, including those listed in subdivision 6;

(3) with whom the recording may be shared under subdivision 10 or 11; and

(4) the resident's ability to decline all recording.

(c) A resident, or resident representative when consenting on behalf of the resident, may consent to electronic monitoring with any conditions of the resident's or resident representative's choosing, including the list of standard conditions provided in subdivision 6. A resident, or resident representative when consenting on behalf of the resident, may request that the electronic monitoring device be turned off or the visual or audio recording component of the electronic monitoring device be blocked at any time.

(d) Prior to implementing electronic monitoring, a resident, or resident representative when acting on behalf of the resident, must obtain the written consent on the notification

and consent form of any other resident residing in the shared room or shared private living unit. A roommate's or roommate's resident representative's written consent must comply with the requirements of paragraphs (a) to (c). Consent by a roommate or a roommate's resident representative under this paragraph authorizes the resident's use of any recording obtained under this section, as provided under subdivision 10 or 11.

(e) Any resident conducting electronic monitoring must immediately remove or disable an electronic monitoring device prior to a new roommate moving into a shared room or shared private living unit, unless the resident obtains the roommate's or roommate's resident representative's written consent as provided under paragraph (d) prior to the roommate moving into the shared room or shared private living unit. Upon obtaining the new roommate's signed notification and consent form and submitting the form to the facility as required under subdivision 5, the resident may resume electronic monitoring.

(f) The resident or roommate, or the resident representative or roommate's resident representative if the representative is consenting on behalf of the resident or roommate, may withdraw consent at any time and the withdrawal of consent must be documented on the original consent form as provided under subdivision 5, paragraph (d).

Subd. 4. **Refusal of roommate to consent.** If a resident of a facility who is residing in a shared room or shared living unit, or the resident representative of such a resident when acting on behalf of the resident, wants to conduct electronic monitoring and another resident living in or moving into the same shared room or shared living unit refuses to consent to the use of an electronic monitoring device, the facility shall make a reasonable attempt to accommodate the resident who wants to conduct electronic monitoring. A facility has met the requirement to make a reasonable attempt to accommodate a resident or resident representative who wants to conduct electronic monitoring when, upon notification that a roommate has not consented to the use of an electronic monitoring device in the resident's room, the facility offers to move the resident to another shared room or shared living unit that is available at the time of the request. If a resident chooses to reside in a private room or private living unit in a facility in order to accommodate the use of an electronic monitoring device, the resident must pay either the private room rate in a nursing home setting, or the applicable rent in a housing with services establishment or assisted living facility. If a facility is unable to accommodate a resident due to lack of space, the facility must reevaluate the request every two weeks until the request is fulfilled. A facility is not required to provide a private room, a single-bed room, or a private living unit to a resident who is unable to pay.

Subd. 5. **Notice to facility; exceptions.** (a) Electronic monitoring may begin only after the resident or resident representative who intends to place an electronic monitoring device and any roommate or roommate's resident representative completes the notification and consent form and submits the form to the facility.

(b) Notwithstanding paragraph (a), the resident or resident representative who intends to place an electronic monitoring device may do so without submitting a notification and consent form to the facility for up to 30 days:

(1) if the resident or the resident representative reasonably fears retaliation against the resident by the facility, timely submits the completed notification and consent form to the Office of Ombudsman for Long-Term Care, and timely submits a Minnesota Adult Abuse Reporting Center report or police report, or both, upon evidence from the electronic monitoring device that suspected maltreatment has occurred;

(2) if there has not been a timely written response from the facility to a written communication from the resident or resident representative expressing a concern prompting the desire for placement of an electronic monitoring device and if the resident or a resident representative timely submits a completed notification and consent form to the Office of Ombudsman for Long-Term Care; or

(3) if the resident or resident representative has already submitted a Minnesota Adult Abuse Reporting Center report or police report regarding the resident's concerns prompting the desire for placement and if the resident or a resident representative timely submits a completed notification and consent form to the Office of Ombudsman for Long-Term Care.

(c) Upon receipt of any completed notification and consent form, the facility must place the original form in the resident's file or file the original form with the resident's housing with services contract. The facility must provide a copy to the resident and the resident's roommate, if applicable.

(d) In the event that a resident or roommate, or the resident representative or roommate's resident representative if the representative is consenting on behalf of the resident or roommate, chooses to alter the conditions under which consent to electronic monitoring is given or chooses to withdraw consent to electronic monitoring, the facility must make available the original notification and consent form so that it may be updated. Upon receipt of the updated form, the facility must place the updated form in the resident's file or file the original form with the resident's signed housing with services contract. The facility must provide a copy of the updated form to the resident and the resident's roommate, if applicable.

(e) If a new roommate, or the new roommate's resident representative when consenting on behalf of the new roommate, does not submit to the facility a completed notification and consent form and the resident conducting the electronic monitoring does not remove or disable the electronic monitoring device, the facility must remove the electronic monitoring device.

(f) If a roommate, or the roommate's resident representative when withdrawing consent on behalf of the roommate, submits an updated notification and consent form withdrawing consent and the resident conducting electronic monitoring does not remove or disable the electronic monitoring device, the facility must remove the electronic monitoring device.

Subd. 6. **Form requirements.** (a) The notification and consent form completed by the resident must include, at a minimum, the following information:

(1) the resident's signed consent to electronic monitoring or the signature of the resident representative, if applicable. If a person other than the resident signs the consent form, the form must document the following:

(i) the date the resident was asked if the resident wants electronic monitoring to be conducted;

(ii) who was present when the resident was asked;

(iii) an acknowledgment that the resident did not affirmatively object; and

(iv) the source of authority allowing the resident representative to sign the notification and consent form on the resident's behalf;

(2) the resident's roommate's signed consent or the signature of the roommate's resident representative, if applicable. If a roommate's resident representative signs the consent form, the form must document the following:

(i) the date the roommate was asked if the roommate wants electronic monitoring to be conducted;

(ii) who was present when the roommate was asked;

(iii) an acknowledgment that the roommate did not affirmatively object; and

(iv) the source of authority allowing the resident representative to sign the notification and consent form on the roommate's behalf;

(3) the type of electronic monitoring device to be used;

(4) a list of standard conditions or restrictions that the resident or a roommate may elect to place on the use of the electronic monitoring device, including but not limited to:

(i) prohibiting audio recording;

(ii) prohibiting video recording;

(iii) prohibiting broadcasting of audio or video;

(iv) turning off the electronic monitoring device or blocking the visual recording component of the electronic monitoring device for the duration of an exam or procedure by a health care professional;

(v) turning off the electronic monitoring device or blocking the visual recording component of the electronic monitoring device while dressing or bathing is performed; and

(vi) turning off the electronic monitoring device for the duration of a visit with a spiritual adviser, ombudsman, attorney, financial planner, intimate partner, or other visitor;

(5) any other condition or restriction elected by the resident or roommate on the use of an electronic monitoring device;

(6) a statement of the circumstances under which a recording may be disseminated under subdivision 10;

(7) a signature box for documenting that the resident or roommate has withdrawn consent; and

(8) an acknowledgment that the resident, in accordance with subdivision 3, consents to the Office of Ombudsman for Long-Term Care and its representatives disclosing information about the form. Disclosure under this clause shall be limited to:

(i) the fact that the form was received from the resident or resident representative;

(ii) if signed by a resident representative, the name of the resident representative and the source of authority allowing the resident representative to sign the notification and consent form on the resident's behalf; and

(iii) the type of electronic monitoring device placed.

(b) Facilities must make the notification and consent form available to the residents and inform residents of their option to conduct electronic monitoring of their rooms or private living unit.

(c) Notification and consent forms received by the Office of Ombudsman for Long-Term Care are classified under section 256.9744.

Subd. 7. **Costs and installation.** (a) A resident or resident representative choosing to conduct electronic monitoring must do so at the resident's own expense, including paying purchase, installation, maintenance, and removal costs.

(b) If a resident chooses to place an electronic monitoring device that uses Internet technology for visual or audio monitoring, the resident may be responsible for contracting with an Internet service provider.

(c) The facility shall make a reasonable attempt to accommodate the resident's installation needs, including allowing access to the facility's public-use Internet or Wi-Fi systems when available for other public uses. A facility has the burden of proving that a requested accommodation is not reasonable.

(d) All electronic monitoring device installations and supporting services must be UL-listed.

Subd. 8. **Notice to visitors.** (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities."

(b) The facility is responsible for installing and maintaining the signage required in this subdivision.

Subd. 9. **Obstruction of electronic monitoring devices.** (a) A person must not knowingly hamper, obstruct, tamper with, or destroy an electronic monitoring device placed in a resident's room or private living unit without the permission of the resident or resident representative.

(b) It is not a violation of paragraph (a) if a person turns off the electronic monitoring device or blocks the visual recording component of the electronic monitoring device at the direction of the resident or resident representative, or if consent has been withdrawn.

Subd. 10. **Dissemination of recordings.** (a) No person may access any video or audio recording created through authorized electronic monitoring without the written consent of the resident or resident representative.

(b) Except as required under other law, a recording or copy of a recording made as provided in this section may only be disseminated for the purpose of addressing health, safety, or welfare concerns of one or more residents.

(c) A person disseminating a recording or copy of a recording made as provided in this section in violation of paragraph (b) may be civilly or criminally liable.

Subd. 11. **Admissibility of evidence.** Subject to applicable rules of evidence and procedure, any video or audio recording created through electronic monitoring under this section may be admitted into evidence in a civil, criminal, or administrative proceeding.

Subd. 12. **Liability.** (a) For the purposes of state law, the mere presence of an electronic monitoring device in a resident's room or private living unit is not a violation of the resident's right to privacy under section 144.651 or 144A.44.

(b) For the purposes of state law, a facility or home care provider is not civilly or criminally liable for the mere disclosure by a resident or a resident representative of a recording.

Subd. 13. **Immunity from liability.** The Office of Ombudsman for Long-Term Care and representatives of the office are immune from liability for conduct described in section 256.9742, subdivision 2.

Subd. 14. **Resident protections.** (a) A facility must not:

(1) refuse to admit a potential resident or remove a resident because the facility disagrees with the decision of the potential resident, the resident, or a resident representative acting on behalf of the resident regarding electronic monitoring;

(2) retaliate or discriminate against any resident for consenting or refusing to consent to electronic monitoring, as provided in section 144.6512, 144G.07, or 144J.03; or

(3) prevent the placement or use of an electronic monitoring device by a resident who has provided the facility or the Office of Ombudsman for Long-Term Care with notice and consent as required under this section.

(b) Any contractual provision prohibiting, limiting, or otherwise modifying the rights and obligations in this section is contrary to public policy and is void and unenforceable.

Subd. 15. **Employee discipline.** (a) An employee of the facility or an employee of a contractor providing services at the facility who is the subject of proposed corrective or disciplinary action based upon evidence obtained by electronic monitoring must be given access to that evidence for purposes of defending against the proposed action.

(b) An employee who obtains a recording or a copy of the recording must treat the recording or copy confidentially and must not further disseminate it to any other person except as required under law. Any copy of the recording must be returned to the facility or resident who provided the copy when it is no longer needed for purposes of defending against a proposed action.

Subd. 16. **Penalties.** (a) The commissioner may issue a correction order as provided under section 144A.10, 144A.45, or 144A.474, upon a finding that the facility has failed to comply with:

(1) subdivision 5, paragraphs (c) to (f);

(2) subdivision 6, paragraph (b);

(3) subdivision 7, paragraph (c); and

(4) subdivisions 8 to 10 and 14.

(b) The commissioner may exercise the commissioner's authority under section 144D.05 to compel a housing with services establishment to meet the requirements of this section.

**EFFECTIVE DATE.** This section is effective August 1, 2019, and applies to all contracts in effect, entered into, or renewed on or after that date.

Sec. 9. **[144J.06] NO DISCRIMINATION BASED ON SOURCE OF PAYMENT.**

All facilities must, regardless of the source of payment and for all persons seeking to reside or residing in the facility:

(1) provide equal access to quality care; and

(2) establish, maintain, and implement identical policies and practices regarding residency, transfer, and provision and termination of services.

**EFFECTIVE DATE.** This section is effective August 1, 2021.

Sec. 10. **[144J.07] CONSUMER ADVOCACY AND LEGAL SERVICES.**

Upon execution of an assisted living contract, every facility must provide the resident and the resident's legal and designated representatives with the names and contact information, including telephone numbers and e-mail addresses, of:

(1) nonprofit organizations that provide advocacy or legal services to residents including but not limited to the designated protection and advocacy organization in Minnesota that provides advice and representation to individuals with disabilities; and

(2) the Office of Ombudsman for Long-Term Care, including both the state and regional contact information.

**EFFECTIVE DATE.** This section is effective August 1, 2021.

Sec. 11. **[144J.08] INVOLUNTARY DISCHARGES AND SERVICE TERMINATIONS.**

Subdivision 1. **Definitions.** (a) For the purposes of this section and sections 144J.09 and 144J.10, the following terms have the meanings given them.

(b) "Facility" means:

(1) a housing with services establishment registered under section 144D.02 and operating under title protection provided under chapter 144G; or

(2) on or after August 1, 2021, an assisted living facility.

(c) "Refusal to readmit" means a refusal by an assisted living facility, upon a request from a resident or an agent of the resident, to allow the resident to return to the facility, whether or not a notice of termination of housing or services has been issued.

(d) "Termination of housing or services" or "termination" means an involuntary facility-initiated discharge, eviction, transfer, or service termination not initiated at the oral or written request of the resident or to which the resident objects.

Subd. 2. **Prerequisite to termination of housing or services.** Before issuing a notice of termination, a facility must explain in person and in detail the reasons for the termination, and must convene a conference with the resident, the resident's legal representatives, the resident's designated representative, the resident's family, applicable state and social services agencies, and relevant health professionals to identify and offer reasonable accommodations and modifications, interventions, or alternatives to avoid the termination.

Subd. 3. **Permissible reasons to terminate housing or services.** (a) A facility is prohibited from terminating housing or services for grounds other than those specified in paragraphs (b) and (c). A facility initiating a termination under paragraph (b) or (c) must comply with subdivision 2.

(b) A facility may not initiate a termination unless the termination is necessary and the facility produces a written determination, supported by documentation, of the necessity of the termination. A termination is necessary only if:

(1) the resident has engaged in documented conduct that substantially interferes with the rights, health, or safety of other residents;

(2) the resident has committed any of the acts enumerated under section 504B.171 that substantially interfere with the rights, health, or safety of other residents; or

(3) the facility can demonstrate that the resident's needs exceed the scope of services for which the resident contracted or which are included in the resident's service plan.

(c) A facility may initiate a termination for nonpayment, provided the facility:

(1) makes reasonable efforts to accommodate temporary financial hardship;

(2) informs the resident of private subsidies and public benefits options that may be available, including but not limited to benefits available under sections 256B.0915 and 256B.49; and

(3) if the resident applies for public benefits, timely responds to state or county agency questions regarding the application.

(d) A facility may not initiate a termination of housing or services to a resident receiving public benefits in the event of a temporary interruption in benefits. A temporary interruption of benefits does not constitute nonpayment.

Subd. 4. **Notice of termination required.** (a) A facility initiating a termination of housing or services must issue a written notice that complies with subdivision 5 at least 30 days prior to the effective date of the termination to the resident, to the resident's legal representative and designated representative, or if none, to a family member if known, and to the Ombudsman for Long-Term Care.

(b) A facility may relocate a resident with less than 30 days' notice only in the event of emergencies, as provided in subdivision 6.

(c) The notice requirements in paragraph (a) do not apply if the facility's license is restricted by the commissioner or the facility ceases operations. In the event of a license restriction or cessation of operations, the facility must follow the commissioner's directions for resident relocations contained in section 144J.10.

Subd. 5. **Content of notice.** The notice required under subdivision 4 must contain, at a minimum:

(1) the effective date of the termination;

(2) a detailed explanation of the basis for the termination, including, but not limited to, clinical or other supporting rationale;

(3) contact information for, and a statement that the resident has the right to appeal the termination to, the Office of Administrative Hearings;

(4) contact information for the Ombudsman for Long-Term Care;

(5) the name and contact information of a person employed by the facility with whom the resident may discuss the notice of termination of housing or services;

(6) if the termination is for services, a statement that the notice of termination of services does not constitute a termination of housing or an eviction from the resident's home, and that the resident has the right to remain in the facility if the resident can secure necessary services from another provider of the resident's choosing; and

(7) if the resident must relocate:

(i) a statement that the facility must actively participate in a coordinated transfer of the resident's care to a safe and appropriate service provider; and

(ii) the name of and contact information for the new location or provider, or a statement that the location or provider must be identified prior to the effective date of the termination.

Subd. 6. **Exception for emergencies.** (a) A facility may relocate a resident from a facility with less than 30 days' notice if relocation is required:

(1) due to a resident's urgent medical needs and is ordered by a licensed health care professional; or

(2) because of an imminent risk to the health or safety of another resident or a staff member of the facility.

(b) A facility relocating a resident under this subdivision must:

(1) remove the resident to an appropriate location. A private home where the occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel is not an appropriate location; and

(2) provide notice of the contact information for and location to which the resident has been relocated, contact information for any new service provider and for the Ombudsman for Long-Term Care, the reason for the relocation, a statement that, if the resident is refused readmission to the facility, the resident has the right to appeal any refusal to readmit to the Office of Administrative Hearings, and, if ascertainable, the approximate date or range of dates when the resident is expected to return to the facility or a statement that such date is not currently ascertainable, to:

(i) the resident, the resident's legal representative and designated representative, or if none, a family member if known immediately upon relocation of the resident; and

(ii) the Office of Ombudsman for Long-Term Care as soon as practicable if the resident has been relocated from the facility for more than 48 hours.

(c) The resident has the right to return to the facility if the conditions under paragraph (a) no longer exist.

(d) If the facility determines that the resident cannot return to the facility or the facility cannot provide the necessary services to the resident upon return, the facility must as soon as practicable but in no event later than 24 hours after the refusal or determination, comply with subdivision 4, and section 144J.10.

**EFFECTIVE DATE.** (a) This section is effective August 1, 2019, and expires July 31, 2021, for housing with services establishments registered under section 144D.02 and operating under title protection provided by and subject to chapter 144G.

(b) This section is effective for assisted living facilities August 1, 2021.

Sec. 12. **[144J.09] APPEAL OF TERMINATION OF HOUSING OR SERVICES.**

Subdivision 1. **Right to appeal termination of housing or services.** A resident, the resident's legal representative or designated representative, or a family member, has the right to appeal a termination of housing or services or a facility's refusal to readmit the resident after an emergency relocation and to request a contested case hearing with the Office of Administrative Hearings.

Subd. 2. **Appeals process.** (a) An appeal and request for a contested case hearing must be filed in writing or electronically as authorized by the chief administrative law judge.

(b) The Office of Administrative Hearings must conduct an expedited hearing as soon as practicable, and in any event no later than 14 calendar days after the office receives the request and within three business days in the event of an appeal of a refusal to readmit. The hearing must be held at the facility where the resident lives, unless it is impractical or the parties agree to a different place. The hearing is not a formal evidentiary hearing. The hearing may also be attended by telephone as allowed by the administrative law judge, after considering how a telephonic hearing will affect the resident's ability to participate. The hearing shall be limited to the amount of time necessary for the participants to expeditiously present the facts about the proposed termination or refusal to readmit. The administrative law judge shall issue a recommendation to the commissioner as soon as practicable, and in any event no later than ten calendar days after the hearing or within two calendar days after the hearing in the case of a refusal to readmit.

(c) The facility bears the burden of proof to establish by a preponderance of the evidence that the termination of housing or services or the refusal to readmit is permissible under law and does not constitute retaliation under section 144G.07 or 144J.03.

(d) Appeals from final determinations issued by the Office of Administrative Hearings shall be as provided in sections 14.63 to 14.68.

(e) The Office of Administrative Hearings must grant the appeal and the commissioner of health may order the assisted living facility to rescind the termination of housing and services or readmit the resident if:

(1) the termination or refusal to readmit was in violation of state or federal law;

(2) the resident cures or demonstrates the ability to cure the reason for the termination or refusal to readmit, or has identified any reasonable accommodation or modification, intervention, or alternative to the termination;

(3) termination would result in great harm or potential great harm to the resident as determined by a totality of the circumstances; or

(4) the facility has failed to identify a safe and appropriate location to which the resident is to be relocated as required under section 144J.10.

(f) The Office of Administrative Hearings has the authority to make any other determinations or orders regarding any conditions that may be placed upon the resident's readmission or continued residency, including but not limited to changes to the service plan or required increases in services.

(g) Nothing in this section limits the right of a resident or the resident's designated representative to request or receive assistance from the Office of Ombudsman for Long-Term Care and the protection and advocacy agency protection and advocacy system designated by the state under Code of Federal Regulations, title 45, section 1326.21, concerning the termination of housing or services.

Subd. 3. **Representation at the hearing.** Parties may, but are not required to, be represented by counsel at a contested case hearing on an appeal. The appearance of a party without counsel does not constitute the unauthorized practice of law.

Subd. 4. **Service provision while appeal pending.** Housing or services may not be terminated during the pendency of an appeal and until a final determination is made by the Office of Administrative Hearings.

**EFFECTIVE DATE.** (a) This section is effective August 1, 2019, and expires July 31, 2021, for housing with services establishments registered under section 144D.02 and operating under title protection provided by and subject to chapter 144G.

(b) This section is effective for assisted living facilities August 1, 2021.

Sec. 13. **[144J.10] HOUSING AND SERVICE TERMINATION; RELOCATION PLANNING.**

Subdivision 1. **Duties of the facility.** If a facility terminates housing or services, if a facility intends to cease operations, or if a facility's license is restricted by the commissioner requiring termination of housing or services to residents, the facility:

(1) in the event of a termination of housing, has an affirmative duty to ensure a coordinated and orderly transfer of the resident to a safe location that is appropriate for the resident. The facility must identify that location prior to any appeal hearing;

(2) in the event of a termination of services, has an affirmative duty to ensure a coordinated and orderly transfer of the resident to an appropriate service provider, if services are still needed and desired by the resident. The facility must identify the provider prior to any appeal hearing; and

(3) must consult and cooperate with the resident; the resident's legal representatives, designated representative, and family members; any interested professionals, including case managers; and applicable agencies to consider the resident's goals and make arrangements to relocate the resident.

Subd. 2. **Safe location.** A safe location is not a private home where the occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel. A facility may not terminate a resident's housing or services if the resident will, as a result of the termination, become homeless, as that term is defined in section 116L.361, subdivision 5, or if an adequate and safe discharge location or adequate and needed service provider has not been identified.

Subd. 3. **Written relocation plan required.** The facility must prepare a written relocation plan for a resident being relocated. The plan must:

(1) contain all the necessary steps to be taken to reduce transfer trauma; and

(2) specify the measures needed until relocation that protect the resident and meet the resident's health and safety needs.

Subd. 4. **No relocation without receiving setting accepting.** A facility may not relocate the resident unless the place to which the resident will be relocated indicates acceptance of the resident.

Subd. 5. **No termination of services without another provider.** If a resident continues to need and desire the services provided by the facility, the facility may not terminate services unless another service provider has indicated that it will provide those services.

Subd. 6. **Information that must be conveyed.** If a resident is relocated to another facility or to a nursing home, or if care is transferred to another provider, the facility must timely convey to that facility, nursing home, or provider:

(1) the resident's full name, date of birth, and insurance information;

(2) the name, telephone number, and address of the resident's designated representatives and legal representatives, if any;

(3) the resident's current documented diagnoses that are relevant to the services being provided;

(4) the resident's known allergies that are relevant to the services being provided;

(5) the name and telephone number of the resident's physician, if known, and the current physician orders that are relevant to the services being provided;

(6) all medication administration records that are relevant to the services being provided;

(7) the most recent resident assessment, if relevant to the services being provided; and

(8) copies of health care directives, "do not resuscitate" orders, and any guardianship orders or powers of attorney.

Subd. 7. **Final accounting; return of money and property.** (a) Within 30 days of the effective date of the termination of housing or services, the facility must:

(1) provide to the resident, resident's legal representatives, and the resident's designated representative a final statement of account;

(2) provide any refunds due;

(3) return any money, property, or valuables held in trust or custody by the facility; and

(4) as required under section 504B.178, refund the resident's security deposit unless it is applied to the first month's charges.

**EFFECTIVE DATE.** (a) This section is effective August 1, 2019, and expires July 31, 2021, for housing with services establishments registered under section 144D.02 and operating under title protection provided by and subject to chapter 144G.

(b) This section is effective for assisted living facilities August 1, 2021.

Sec. 14. **[144J.11] FORCED ARBITRATION.**

(a) An assisted living facility must affirmatively disclose, orally and conspicuously in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action.

(b) A forced arbitration requirement must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to Minnesota law and any other applicable federal or local law. Any civil actions by any litigant must be taken in Minnesota judicial or administrative courts.

(c) A forced arbitration provision must not be unconscionable. All or the portion of a forced arbitration provision found by a court to be unconscionable shall have no effect on the remaining provisions, terms, or conditions of the contract.

**EFFECTIVE DATE.** This section is effective August 1, 2019, for contracts entered into on or after that date.

Sec. 15. **[144J.12] VIOLATION OF RIGHTS.**

(a) A resident who meets the criteria under section 325F.71, subdivision 1, has a cause of action under section 325F.71, subdivision 4, for the violation of section 144J.02, subdivisions 12, 15, and 18, or section 144J.04.

(b) A resident who meets the criteria under section 325F.71, subdivision 1, has a cause of action under section 325F.71, subdivision 4, for the violation of section 144J.03, unless the resident otherwise has a cause of action under section 626.557, subdivision 17.

**EFFECTIVE DATE.** This section is effective August 1, 2021.

Sec. 16. **[144J.13] APPLICABILITY OF OTHER LAWS.**

Assisted living facilities:

(1) are subject to and must comply with chapter 504B;

(2) must comply with section 325F.72; and

(3) are not required to obtain a lodging license under chapter 157 and related rules.

**EFFECTIVE DATE.** This section is effective August 1, 2021.

Sec. 17. Minnesota Statutes 2018, section 325F.72, subdivision 4, is amended to read:

Subd. 4. **Remedy.** The attorney general may seek the remedies set forth in section 8.31 for repeated and intentional violations of this section. ~~However, no private right of action may be maintained as provided under section 8.31, subdivision 3a.~~

## ARTICLE 15
## INDEPENDENT SENIOR LIVING FACILITIES

Section 1. **[144K.01] DEFINITIONS.**

Subdivision 1. **Applicability.** For the purposes of this chapter, the definitions in this section have the meanings given.

Subd. 2. **Dementia.** "Dementia" has the meaning given in section 144I.01, subdivision 16.

Subd. 3. **Designated representative.** "Designated representative" means a person designated in writing by the resident in a residency and service contract and identified in the resident's records on file with the independent senior living facility.

Subd. 4. **Facility.** "Facility" means an independent senior living facility.

Subd. 5. **Independent senior living facility.** "Independent senior living facility" means a facility that, for a fee, provides sleeping accommodations to one or more adults and offers or provides one or more supportive services directly or through a related supportive services provider. For purposes of this chapter, independent senior living facility does not include:

(1) emergency shelter, transitional housing, or any other residential units serving exclusively or primarily homeless individuals, as defined under section 116L.361;

(2) a nursing home licensed under chapter 144A;

(3) a hospital, certified boarding care home, or supervised living facility licensed under sections 144.50 to 144.56;

(4) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D or 245G;

(5) a lodging establishment serving as a shelter for individuals fleeing domestic violence;

(6) services and residential settings licensed under chapter 245A, including adult foster care and services and settings governed under the standards in chapter 245D;

(7) private homes where the residents own or rent the home and control all aspects of the property and building;

(8) a duly organized condominium, cooperative, and common interest community, or owners' association of the condominium, cooperative, and common interest community where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units;

(9) temporary family health care dwellings as defined in sections 394.307 and 462.3593;

(10) settings offering services conducted by and for the adherents of any recognized church or religious denomination for its members through spiritual means or by prayer for healing;

(11) housing financed pursuant to sections 462A.37 and 462A.375, units financed with low-income housing tax credits pursuant to United States Code, title 26, section 42, and units financed by the Minnesota Housing Finance Agency that are intended to serve individuals with disabilities or individuals who are homeless;

(12) rental housing developed under United States Code, title 42, section 1437, or United States Code, title 12, section 1701q;

(13) rental housing designated for occupancy by only elderly or elderly and disabled residents under United States Code, title 42, section 1437e, or rental housing for qualifying families under Code of Federal Regulations, title 24, section 983.56;

(14) rental housing funded under United States Code, title 42, chapter 89, or United States Code, title 42, section 8011; or

(15) an assisted living facility or assisted living facility with dementia care licensed under chapter 144I.

Subd. 6. **Manager.** "Manager" means a manager of an independent senior living facility.

Subd. 7. **Residency and services contract or contract.** "Residency and services contract" or "contract" means the legal agreement between an independent senior living facility and a resident for the provision of housing and supportive services.

Subd. 8. **Related supportive services provider.** "Related supportive services provider" means a service provider that provides supportive services to a resident under a business relationship or other affiliation with the independent senior living facility.

Subd. 9. **Resident.** "Resident" means a person residing in an independent senior living facility.

Subd. 10. **Supportive services.** "Supportive services" means:

(1) assistance with laundry, shopping, and household chores;

(2) housekeeping services;

(3) provision of meals or assistance with meals or food preparation;

(4) help with arranging, or arranging transportation to, medical, social, recreational, personal, or social services appointments; or

(5) provision of social or recreational services.

Arranging for services does not include making referrals or contacting a service provider in an emergency.

Subd. 11. **Wellness check services.** "Wellness check services" means having, maintaining, and documenting a system to, by any means, check on the health, safety, and well-being of a resident.

Sec. 2. **[144K.02] DECEPTIVE MARKETING AND BUSINESS PRACTICES PROHIBITED.**

(a) No employee or agent of any independent senior living facility may make any false, fraudulent, deceptive, or misleading statements or representations or material omissions in marketing, advertising, or any other description or representation of care or services.

(b) No residency and services contract required under section 144K.03, subdivision 1, may include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law.

(c) No facility may advertise or represent that the facility is an assisted living facility as defined in section 144I.01, subdivision 6, or an assisted living facility with dementia care as defined in section 144I.01, subdivision 8.

Sec. 3. **[144K.025] REQUIRED DISCLOSURE BY FACILITY.**

An independent senior living facility must disclose to prospective residents and residents that the facility is not licensed as an assisted living facility and is not permitted to provide assisted living services, as defined in section 144I.01, subdivision 7, either directly or through a provider under a business relationship or other affiliation with the facility.

Sec. 4. **[144K.03] RESIDENCY AND SERVICES CONTRACT.**

Subdivision 1. **Contract required.** (a) No independent senior living facility may operate in this state unless a written contract that meets the requirements of subdivision 2 is executed between the facility and each resident and unless the establishment operates in accordance with the terms of the contract.

(b) The facility must give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendums have been signed by the resident.

(c) The contract must contain all the terms concerning the provision of housing and supportive services, whether the services are provided directly or through a related supportive services provider.

Subd. 2. **Contents of contract.** A residency and services contract must include at least the following elements in itself or through supporting documents or attachments:

(1) the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:

(i) the facility and, where applicable, the related supportive services provider;

(ii) the managing agent of the facility, if applicable; and

(iii) at least one natural person who is authorized to accept service of process on behalf of the facility;

(2) the term of the contract;

(3) a description of all the terms and conditions of the contract, including a description of the services to be provided and any limitations to the services provided to the resident for the contracted amount;

(4) a delineation of the grounds under which the resident may be evicted or have services terminated;

(5) billing and payment procedures and requirements;

(6) a statement regarding the ability of a resident to receive services from service providers with whom the facility does not have a business relationship;

(7) a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints;

(8) the toll-free complaint line for the Office of Ombudsman for Long-Term Care; and

(9) a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the facility is located.

Subd. 3. **Designation of representative.** (a) Before or at the time of execution of a residency and services contract, every facility must offer the resident the opportunity to identify a designated representative in writing in the contract and provide the following verbatim notice on a document separate from the contract:

**RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.**

You have the right to name anyone as your "Designated Representative" to assist you or, if you are unable, advocate on your behalf. A "Designated Representative" does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent").

(b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 5, the resident has the right at any time to add or change the name and contact information of the designated representative.

Subd. 4. **Contracts are consumer contracts.** A contract under this section is a consumer contract under sections 325G.29 to 325G.37.

Subd. 5. **Additions and amendments to contract.** The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident or resident's designated representative and the facility, a new contract or an addendum to the existing contract must be executed and signed and provided to the resident and the resident's legal representative.

Subd. 6. **Contracts in permanent files.** Residency and services contracts and related documents executed by each resident must be maintained by the facility in files from the date of execution until three years after the contract is terminated.

Subd. 7. **Waivers of liability prohibited.** The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, and must not include any provision that requires or implies a lesser standard of responsibility than is required by law.

Subd. 8. **Contract restriction.** No independent senior living facility may offer wellness check services.

Sec. 5. **[144K.04] TERMINATION OF RESIDENCY AND SERVICES CONTRACT.**

Subdivision 1. **Notice required.** An independent senior living facility must provide at least 30 days prior notice of a termination of the residency and services contract.

Subd. 2. **Content of notice.** The notice required under subdivision 1 must contain, at a minimum:

(1) the effective date of termination of the contract;

(2) a detailed explanation of the basis for the termination;

(3) a list of known facilities in the immediate geographic area;

(4) information on how to contact the Office of Ombudsman for Long-Term Care and the Ombudsman for Mental Health and Developmental Disabilities;

(6) a statement of any steps the resident can take to avoid termination;

(7) the name and contact information of a person employed by the facility with whom the resident may discuss the notice of termination and, without extending the termination notice period, an affirmative offer to meet with the resident and any person or persons of the resident's choosing to discuss the termination;

(8) a statement that, with respect to the notice of termination, reasonable accommodation is available for a resident with a disability; and

(9) an explanation that:

(i) the resident must vacate the apartment, along with all personal possessions, on or before the effective date of termination;

(ii) failure to vacate the apartment by the date of termination may result in the filing of an eviction action in court by the facility, and that the resident may present a defense, if any, to the court at that time; and

(iii) the resident may seek legal counsel in connection with the notice of termination.

Sec. 6. **[144K.05] MANAGER REQUIREMENTS.**

(a) The manager of an independent senior living facility must obtain at least 30 hours of continuing education every two years of employment as the manager in topics relevant to the operations of the facility and the needs of its residents. Continuing education earned

to maintain a professional license, such as a nursing home administrator license, nursing license, social worker license, or real estate license, may be used to satisfy this requirement. The continuing education must include at least four hours of documented training on dementia and related disorders, activities of daily living, problem solving with challenging behaviors, and communication skills within 160 working hours of hire and two hours of training on these topics for each 12 months of employment thereafter.

(b) The facility must maintain records for at least three years demonstrating that the manager has attended educational programs as required by this section. New managers may satisfy the initial dementia training requirements by producing written proof of having previously completed required training within the past 18 months.

Sec. 7. **[144K.06] FIRE PROTECTION AND PHYSICAL ENVIRONMENT.**

Subdivision 1. **Comprehensive fire protection system required.** Every independent senior living facility must have a comprehensive fire protection system that includes:

(1) protection throughout the facility by an approved supervised automatic sprinkler system according to building code requirements established in Minnesota Rules, part 1305.0903, or smoke detectors in each occupied room installed and maintained in accordance with the National Fire Protection Association (NFPA) Standard 72;

(2) portable fire extinguishers installed and tested in accordance with the NFPA Standard 10; and

(3) the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment kept in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.

Subd. 2. **Fire drills.** Fire drills shall be conducted in accordance with the residential board and care requirements in the Life Safety Code.

Sec. 8. **[144K.07] EMERGENCY PLANNING.**

Subdivision 1. **Requirements.** Each independent senior living facility must meet the following requirements:

(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in-place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;

(2) post an emergency disaster plan prominently;

(3) provide building emergency exit diagrams to all residents upon signing a residency and services contract;

(4) post emergency exit diagrams on each floor; and

(5) have a written policy and procedure regarding missing residents.

Subd. 2. **Emergency and disaster training.** Each independent senior living facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training available to all residents annually. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.

Sec. 9. **[144K.08] OTHER LAWS.**

An independent senior living facility must comply with chapter 504B and must obtain and maintain all other licenses, permits, registrations, or other governmental approvals required of it. No independent senior living facility shall be required to be licensed as a boarding establishment, food and beverage service establishment, hotel or motel, lodging establishment, or resort or restaurant as defined in section 157.15.

**EFFECTIVE DATE.** This section is effective August 1, 2021.

Sec. 10. **[144K.09] ENFORCEMENT.**

(a) A violation of this chapter constitutes a violation of section 325F.69, subdivision 1. The attorney general may enforce this section using the remedies in section 325F.70.

(b) A resident who meets the criteria in section 325F.71, subdivision 1, has a cause of action under section 325F.71, subdivision 4, for a violation of this chapter.

**EFFECTIVE DATE.** This section is effective August 1, 2021.

## ARTICLE 16
## ASSISTED LIVING LICENSURE

Section 1. Minnesota Statutes 2018, section 144.122, is amended to read:

**144.122 LICENSE, PERMIT, AND SURVEY FEES.**

(a) The state commissioner of health, by rule, may prescribe procedures and fees for filing with the commissioner as prescribed by statute and for the issuance of original and renewal permits, licenses, registrations, and certifications issued under authority of the

commissioner. The expiration dates of the various licenses, permits, registrations, and certifications as prescribed by the rules shall be plainly marked thereon. Fees may include application and examination fees and a penalty fee for renewal applications submitted after the expiration date of the previously issued permit, license, registration, and certification. The commissioner may also prescribe, by rule, reduced fees for permits, licenses, registrations, and certifications when the application therefor is submitted during the last three months of the permit, license, registration, or certification period. Fees proposed to be prescribed in the rules shall be first approved by the Department of Management and Budget. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be in an amount so that the total fees collected by the commissioner will, where practical, approximate the cost to the commissioner in administering the program. All fees collected shall be deposited in the state treasury and credited to the state government special revenue fund unless otherwise specifically appropriated by law for specific purposes.

(b) The commissioner may charge a fee for voluntary certification of medical laboratories and environmental laboratories, and for environmental and medical laboratory services provided by the department, without complying with paragraph (a) or chapter 14. Fees charged for environment and medical laboratory services provided by the department must be approximately equal to the costs of providing the services.

(c) The commissioner may develop a schedule of fees for diagnostic evaluations conducted at clinics held by the services for children with disabilities program. All receipts generated by the program are annually appropriated to the commissioner for use in the maternal and child health program.

(d) The commissioner shall set license fees for hospitals and nursing homes that are not boarding care homes at the following levels:

| | |
|---|---|
| Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and American Osteopathic Association (AOA) hospitals | $7,655 plus $16 per bed |
| Non-JCAHO and non-AOA hospitals | $5,280 plus $250 per bed |
| Nursing home | $183 plus $91 per bed until June 30, 2018. $183 plus $100 per bed between July 1, 2018, and June 30, 2020. $183 plus $105 per bed beginning July 1, 2020. |

The commissioner shall set license fees for outpatient surgical centers, boarding care homes, ~~and~~ supervised living facilities, assisted living facilities, and assisted living facilities with dementia care at the following levels:

| | |
|---|---|
| Outpatient surgical centers | $3,712 |
| Boarding care homes | $183 plus $91 per bed |
| Supervised living facilities | $183 plus $91 per bed. |
| Assisted living facilities with dementia care | $..... plus $..... per bed. |
| Assisted living facilities | $..... plus $..... per bed. |

Fees collected under this paragraph are nonrefundable. The fees are nonrefundable even if received before July 1, 2017, for licenses or registrations being issued effective July 1, 2017, or later.

(e) Unless prohibited by federal law, the commissioner of health shall charge applicants the following fees to cover the cost of any initial certification surveys required to determine a provider's eligibility to participate in the Medicare or Medicaid program:

| | |
|---|---|
| Prospective payment surveys for hospitals | $ 900 |
| Swing bed surveys for nursing homes | $ 1,200 |
| Psychiatric hospitals | $ 1,400 |
| Rural health facilities | $ 1,100 |
| Portable x-ray providers | $ 500 |
| Home health agencies | $ 1,800 |
| Outpatient therapy agencies | $ 800 |
| End stage renal dialysis providers | $ 2,100 |
| Independent therapists | $ 800 |
| Comprehensive rehabilitation outpatient facilities | $ 1,200 |
| Hospice providers | $ 1,700 |
| Ambulatory surgical providers | $ 1,800 |
| Hospitals | $ 4,200 |
| Other provider categories or additional resurveys required to complete initial certification | Actual surveyor costs: average surveyor cost x number of hours for the survey process. |

These fees shall be submitted at the time of the application for federal certification and shall not be refunded. All fees collected after the date that the imposition of fees is not prohibited by federal law shall be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 2. **[144I.01] DEFINITIONS.**

Subdivision 1. **Applicability.** For the purposes of this chapter, the definitions in this section have the meanings given.

Subd. 2. **Adult.** "Adult" means a natural person who has attained the age of 18 years.

Subd. 3. **Agent.** "Agent" means the person upon whom all notices and orders shall be served and who is authorized to accept service of notices and orders on behalf of the facility.

Subd. 4. **Applicant.** "Applicant" means an individual, legal entity, controlling individual, or other organization that has applied for licensure under this chapter.

Subd. 5. **Assisted living administrator.** "Assisted living administrator" means a person who administers, manages, supervises, or is in general administrative charge of an assisted living facility, whether or not the individual has an ownership interest in the facility, and whether or not the person's functions or duties are shared with one or more individuals and who is licensed by the Board of Executives for Long Term Services and Supports pursuant to section 144I.31.

Subd. 6. **Assisted living facility.** "Assisted living facility" means a licensed facility that: (1) provides sleeping accommodations to one or more adults; and (2) provides basic care services and comprehensive assisted living services. For purposes of this chapter, assisted living facility does not include:

(i) emergency shelter, transitional housing, or any other residential units serving exclusively or primarily homeless individuals, as defined under section 116L.361;

(ii) a nursing home licensed under chapter 144A;

(iii) a hospital, certified boarding care, or supervised living facility licensed under sections 144.50 to 144.56;

(iv) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D or 245G, except lodging establishments that provide dementia care services;

(v) a lodging establishment serving as a shelter for individuals fleeing domestic violence;

(vi) services and residential settings licensed under chapter 245A, including adult foster care and services and settings governed under the standards in chapter 245D;

(vii) private homes where the residents own or rent the home and control all aspects of the property and building;

(viii) a duly organized condominium, cooperative, and common interest community, or owners' association of the condominium, cooperative, and common interest community where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units;

(ix) temporary family health care dwellings as defined in sections 394.307 and 462.3593;

(x) settings offering services conducted by and for the adherents of any recognized church or religious denomination for its members through spiritual means or by prayer for healing;

(xi) housing financed pursuant to sections 462A.37 and 462A.375, units financed with low-income housing tax credits pursuant to United States Code, title 26, section 42, and units financed by the Minnesota Housing Finance Agency that are intended to serve individuals with disabilities or individuals who are homeless;

(xii) rental housing developed under United States Code, title 42, section 1437, or United States Code, title 12, section 1701q;

(xiii) rental housing designated for occupancy by only elderly or elderly and disabled residents under United States Code, title 42, section 1437e, or rental housing for qualifying families under Code of Federal Regulations, title 24, section 983.56; or

(xiv) rental housing funded under United States Code, title 42, chapter 89, or United States Code, title 42, section 8011.

Subd. 7. **Assisted living services.** "Assisted living services" include any of the basic care services and one or more of the following:

(1) services of an advanced practice nurse, registered nurse, licensed practical nurse, physical therapist, respiratory therapist, occupational therapist, speech-language pathologist, dietitian or nutritionist, or social worker;

(2) tasks delegated to unlicensed personnel by a registered nurse or assigned by a licensed health professional within the person's scope of practice;

(3) medication management services;

(4) hands-on assistance with transfers and mobility;

(5) treatment and therapies;

(6) assisting residents with eating when the clients have complicated eating problems as identified in the resident record or through an assessment such as difficulty swallowing, recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous instruments to be fed; or

(7) providing other complex or specialty health care services.

Subd. 8. **Assisted living facility with dementia care.** "Assisted living facility with dementia care" means a licensed assisted living facility that also provides dementia care services. An assisted living facility with dementia care may also have a secured dementia care unit.

Subd. 9. **Assisted living facility contract.** "Assisted living facility contract" means the legal agreement between an assisted living facility and a resident for the provision of housing and services.

Subd. 10. **Basic care services.** "Basic care services" means assistive tasks provided by licensed or unlicensed personnel that include:

(1) assisting with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing;

(2) providing standby assistance;

(3) providing verbal or visual reminders to the resident to take regularly scheduled medication, which includes bringing the client previously set-up medication, medication in original containers, or liquid or food to accompany the medication;

(4) providing verbal or visual reminders to the client to perform regularly scheduled treatments and exercises;

(5) preparing modified diets ordered by a licensed health professional;

(6) having, maintaining, and documenting a system to, by any means, check on the health, safety, and well-being of a resident; and

(7) supportive services in addition to the provision of at least one of the activities in clauses (1) to (5).

Subd. 11. **Change of ownership.** "Change of ownership" means a change in the individual or legal entity that is responsible for the operation of a facility.

Subd. 12. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 13. **Compliance officer.** "Compliance officer" means a designated individual who is qualified by knowledge, training, and experience in health care or risk management to promote, implement, and oversee the facility's compliance program. The compliance officer shall also exhibit knowledge of relevant regulations; provide expertise in compliance processes; and address fraud, abuse, and waste under this chapter and state and federal law.

Subd. 14. **Controlled substance.** "Controlled substance" has the meaning given in section 152.01, subdivision 4.

Subd. 15. **Controlling individual.** (a) "Controlling individual" means an owner of a facility licensed under this chapter and the following individuals, if applicable:

(1) each officer of the organization, including the chief executive officer and chief financial officer;

(2) the individual designated as the authorized agent under section 245A.04, subdivision 1, paragraph (b);

(3) the individual designated as the compliance officer under section 256B.04, subdivision 21, paragraph (b); and

(4) each managerial official whose responsibilities include the direction of the management or policies of the facility.

(b) Controlling individual also means any owner who directly or indirectly owns five percent or more interest in:

(1) the land on which the facility is located, including a real estate investment trust (REIT);

(2) the structure in which a facility is located;

(3) any mortgage, contract for deed, or other obligation secured in whole or part by the land or structure comprising the facility; or

(4) any lease or sublease of the land, structure, or facilities comprising the facility.

(c) Controlling individual does not include:

(1) a bank, savings bank, trust company, savings association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity operates a program directly or through a subsidiary;

(2) government and government-sponsored entities such as the U.S. Department of Housing and Urban Development, Ginnie Mae, Fannie Mae, Freddie Mac, and the Minnesota Housing Finance Agency which provide loans, financing, and insurance products for housing sites;

(3) an individual who is a state or federal official, or a state or federal employee, or a member or employee of the governing body of a political subdivision of the state or federal government that operates one or more facilities, unless the individual is also an officer, owner, or managerial official of the facility, receives remuneration from the facility, or owns any of the beneficial interests not excluded in this subdivision;

(4) an individual who owns less than five percent of the outstanding common shares of a corporation:

(i) whose securities are exempt under section 80A.45, clause (6); or

(ii) whose transactions are exempt under section 80A.46, clause (2);

(5) an individual who is a member of an organization exempt from taxation under section 290.05, unless the individual is also an officer, owner, or managerial official of the license or owns any of the beneficial interests not excluded in this subdivision. This clause does not exclude from the definition of controlling individual an organization that is exempt from taxation; or

(6) an employee stock ownership plan trust, or a participant or board member of an employee stock ownership plan, unless the participant or board member is a controlling individual.

Subd. 16. **Dementia.** "Dementia" means the loss of intellectual function of sufficient severity that interferes with an individual's daily functioning. Dementia affects an individual's memory and ability to think, reason, speak, and move. Symptoms may also include changes in personality, mood, and behavior. Irreversible dementias include but are not limited to:

(1) Alzheimer's disease;

(2) vascular dementia;

(3) Lewy body dementia;

(4) frontal-temporal lobe dementia;

(5) alcohol dementia;

(6) Huntington's disease; and

(7) Creutzfeldt-Jakob disease.

Subd. 17. **Dementia care services.** "Dementia care services" means a distinct form of long-term care designed to meet the specific needs of an individual with dementia.

Subd. 18. **Dementia-trained staff.** "Dementia-trained staff" means any employee that has completed the minimum training requirements and has demonstrated knowledge and understanding in supporting individuals with dementia.

Subd. 19. **Designated representative.** "Designated representative" means one of the following in the order of priority listed, to the extent the person may reasonably be identified and located:

(1) a court-appointed guardian acting in accordance with the powers granted to the guardian under chapter 524;

(2) a conservator acting in accordance with the powers granted to the conservator under chapter 524;

(3) a health care agent acting in accordance with the powers granted to the health care agent under chapter 145C;

(4) a power of attorney acting in accordance with the powers granted to the attorney-in-fact under chapter 523; or

(5) the resident representative.

Subd. 20. **Dietary supplement.** "Dietary supplement" means a product taken by mouth that contains a dietary ingredient intended to supplement the diet. Dietary ingredients may include vitamins, minerals, herbs or other botanicals, amino acids, and substances such as enzymes, organ tissue, glandulars, or metabolites.

Subd. 21. **Direct contact.** "Direct contact" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to residents of a facility.

Subd. 22. **Direct ownership interest.** "Direct ownership interest" means an individual or organization with the possession of at least five percent equity in capital, stock, or profits of an organization, or who is a member of a limited liability company. An individual with a five percent or more direct ownership is presumed to have an effect on the operation of the facility with respect to factors affecting the care or training provided.

Subd. 23. **Facility.** "Facility" means an assisted living facility and an assisted living facility with dementia care.

Subd. 24. **Hands-on assistance.** "Hands-on assistance" means physical help by another person without which the resident is not able to perform the activity.

Subd. 25. **Indirect ownership interest.** "Indirect ownership interest" means an individual or organization with a direct ownership interest in an entity that has a direct or indirect ownership interest in a facility of at least five percent or more. An individual with a five percent or more indirect ownership is presumed to have an effect on the operation of the facility with respect to factors affecting the care or training provided.

Subd. 26. **Licensed health professional.** "Licensed health professional" means a person licensed in Minnesota to practice the professions described in section 214.01, subdivision 2.

Subd. 27. **Licensed resident bed capacity.** "Licensed resident bed capacity" means the resident occupancy level requested by a licensee and approved by the commissioner.

Subd. 28. **Licensee.** "Licensee" means a person or legal entity to whom the commissioner issues a license for a facility and who is responsible for the management, control, and operation of a facility. A facility must be managed, controlled, and operated in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Subd. 29. **Maltreatment.** "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury or any persistent course of conduct intended to produce mental or emotional distress.

Subd. 30. **Management agreement.** "Management agreement" means a written, executed agreement between a licensee and manager regarding the provision of certain services on behalf of the licensee.

Subd. 31. **Managerial official.** "Managerial official" means an individual who has the decision-making authority related to the operation of the facility and the responsibility for the ongoing management or direction of the policies, services, or employees of the facility.

Subd. 32. **Medication.** "Medication" means a prescription or over-the-counter drug. For purposes of this chapter only, medication includes dietary supplements.

Subd. 33. **Medication administration.** "Medication administration" means performing a set of tasks that includes the following:

(1) checking the client's medication record;

(2) preparing the medication as necessary;

(3) administering the medication to the client;

(4) documenting the administration or reason for not administering the medication; and

(5) reporting to a registered nurse or appropriate licensed health professional any concerns about the medication, the resident, or the resident's refusal to take the medication.

Subd. 34. **Medication management.** "Medication management" means the provision of any of the following medication-related services to a resident:

(1) performing medication setup;

(2) administering medications;

(3) storing and securing medications;

(4) documenting medication activities;

(5) verifying and monitoring the effectiveness of systems to ensure safe handling and administration;

(6) coordinating refills;

(7) handling and implementing changes to prescriptions;

(8) communicating with the pharmacy about the resident's medications; and

(9) coordinating and communicating with the prescriber.

Subd. 35. **Medication reconciliation.** "Medication reconciliation" means the process of identifying the most accurate list of all medications the resident is taking, including the name, dosage, frequency, and route by comparing the resident record to an external list of medications obtained from the resident, hospital, prescriber or other provider.

Subd. 36. **Medication setup.** "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff.

Subd. 37. **New construction.** "New construction" means a new building, renovation, modification, reconstruction, physical changes altering the use of occupancy, or an addition to a building.

Subd. 38. **Nurse.** "Nurse" means a person who is licensed under sections 148.171 to 148.285.

Subd. 39. **Occupational therapist.** "Occupational therapist" means a person who is licensed under sections 148.6401 to 148.6449.

Subd. 40. **Ombudsman.** "Ombudsman" means the ombudsman for long-term care.

Subd. 41. **Owner.** "Owner" means an individual or organization that has a direct or indirect ownership interest of five percent or more in a facility. For purposes of this chapter, "owner of a nonprofit corporation" means the president and treasurer of the board of directors or, for an entity owned by an employee stock ownership plan, means the president and treasurer of the entity. A government entity that is issued a license under this chapter shall be designated the owner. An individual with a five percent or more direct or indirect ownership is presumed to have an effect on the operation of the facility with respect to factors affecting the care or training provided.

Subd. 42. **Over-the-counter drug.** "Over-the-counter drug" means a drug that is not required by federal law to bear the symbol "Rx only."

Subd. 43. **Person-centered planning and service delivery.** "Person-centered planning and service delivery" means services as defined in section 245D.07, subdivision 1a, paragraph (b).

Subd. 44. **Pharmacist.** "Pharmacist" has the meaning given in section 151.01, subdivision 3.

Subd. 45. **Physical therapist.** "Physical therapist" means a person who is licensed under sections 148.65 to 148.78.

Subd. 46. **Physician.** "Physician" means a person who is licensed under chapter 147.

Subd. 47. **Prescriber.** "Prescriber" means a person who is authorized by sections 148.235; 151.01, subdivision 23; and 151.37 to prescribe prescription drugs.

Subd. 48. **Prescription.** "Prescription" has the meaning given in section 151.01, subdivision 16a.

Subd. 49. **Provisional license.** "Provisional license" means the initial license the department issues after approval of a complete written application and before the department completes the provisional license survey and determines that the provisional licensee is in substantial compliance.

Subd. 50. **Regularly scheduled.** "Regularly scheduled" means ordered or planned to be completed at predetermined times or according to a predetermined routine.

Subd. 51. **Reminder.** "Reminder" means providing a verbal or visual reminder to a resident.

Subd. 52. **Resident.** "Resident" means a person living in an assisted living facility.

Subd. 53. **Resident record.** "Resident record" means all records that document information about the services provided to the resident.

Subd. 54. **Resident representative.** "Resident representative" means a person designated in writing by the resident and identified in the resident's records on file with the facility.

Subd. 55. **Respiratory therapist.** "Respiratory therapist" means a person who is licensed under chapter 147C.

Subd. 56. **Revenues.** "Revenues" means all money received by a licensee derived from the provision of home care services, including fees for services and appropriations of public money for home care services.

Subd. 57. **Service plan.** "Service plan" means the written plan between the resident or the resident's representative and the provisional licensee or licensee about the services that will be provided to the resident.

Subd. 58. **Social worker.** "Social worker" means a person who is licensed under chapter 148D or 148E.

Subd. 59. **Speech-language pathologist.** "Speech-language pathologist" has the meaning given in section 148.512.

Subd. 60. **Standby assistance.** "Standby assistance" means the presence of another person within arm's reach to minimize the risk of injury while performing daily activities through physical intervention or cueing to assist a resident with an assistive task by providing cues, oversight, and minimal physical assistance.

Subd. 61. **Substantial compliance.** "Substantial compliance" means complying with the requirements in this chapter sufficiently to prevent unacceptable health or safety risks to residents.

Subd. 62. **Supportive services.** "Supportive services" means:

(1) assistance with laundry, shopping, and household chores;

(2) housekeeping services;

(3) provision or assistance with meals or food preparation;

(4) help with arranging for, or arranging transportation to medical, social, recreational, personal, or social services appointments; or

(5) provision of social or recreational services.

Arranging for services does not include making referrals, or contacting a service provider in an emergency.

Subd. 63. **Survey.** "Survey" means an inspection of a licensee or applicant for licensure for compliance with this chapter.

Subd. 64. **Surveyor.** "Surveyor" means a staff person of the department who is authorized to conduct surveys of assisted living facilities and applicants.

Subd. 65. **Termination of housing or services.** "Termination of housing or services" means a discharge, eviction, transfer, or service termination initiated by the facility. A facility-initiated termination is one which the resident objects to and did not originate through a resident's verbal or written request. A resident-initiated termination is one where a resident

or, if appropriate, a designated representative provided a verbal or written notice of intent to leave the facility. A resident-initiated termination does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment.

Subd. 66. **Treatment or therapy.** "Treatment" or "therapy" means the provision of care, other than medications, ordered or prescribed by a licensed health professional and provided to a resident to cure, rehabilitate, or ease symptoms.

Subd. 67. **Unit of government.** "Unit of government" means a city, county, town, school district, other political subdivision of the state, or an agency of the state or federal government, that includes any instrumentality of a unit of government.

Subd. 68. **Unlicensed personnel.** "Unlicensed personnel" means individuals not otherwise licensed or certified by a governmental health board or agency who provide services to a resident.

Subd. 69. **Verbal.** "Verbal" means oral and not in writing.

Sec. 3. **[144I.02] ASSISTED LIVING FACILITY LICENSE.**

Subdivision 1. **License required.** Beginning August 1, 2021, an entity may not operate an assisted living facility in Minnesota unless it is licensed under this chapter.

Subd. 2. **Licensure categories.** (a) The categories in this subdivision are established for assisted living facility licensure.

(b) An assisted living category is an assisted living facility that provides basic care services and comprehensive assisted living services.

(c) An assisted living facility with dementia care category is an assisted living facility that provides basic care services, comprehensive assisted living services, and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secure dementia care unit.

Subd. 3. **Violations; penalty.** (a) Operating a facility without a license is a misdemeanor punishable by a fine imposed by the commissioner.

(b) A controlling individual of the facility in violation of this section is guilty of a misdemeanor. This paragraph shall not apply to any controlling individual who had no legal authority to affect or change decisions related to the operation of the facility.

(c) The sanctions in this section do not restrict other available sanctions in law.

Sec. 4. **[144I.03] PROVISIONAL LICENSE.**

Subdivision 1. **Provisional license.** (a) Beginning August 1, 2021, for new applicants, the commissioner shall issue a provisional license to each of the licensure categories specified in section 144I.02, subdivision 2, which is effective for up to one year from the license effective date, except that a provisional license may be extended according to subdivision 2, paragraph (c).

(b) Assisted living facilities are subject to evaluation and approval by the commissioner of the facility's physical environment and its operational aspects before a change in ownership or capacity, or an addition of services which necessitates a change in the facility's physical environment.

Subd. 2. **Initial survey; licensure.** (a) During the provisional license period, the commissioner shall survey the provisional licensee after the commissioner is notified or has evidence that the provisional licensee has residents and is providing services.

(b) Within two days of beginning to provide services, the provisional licensee must provide notice to the commissioner that it is serving residents by sending an e-mail to the e-mail address provided by the commissioner. If the provisional licensee does not provide services during the provisional license year period, then the provisional license expires at the end of the period and the applicant must reapply for the provisional facility license.

(c) If the provisional licensee notifies the commissioner that the licensee has residents within 45 days prior to the provisional license expiration, the commissioner may extend the provisional license for up to 60 days in order to allow the commissioner to complete the on-site survey required under this section and follow-up survey visits.

(d) If the provisional licensee is in substantial compliance with the survey, the commissioner shall issue a facility license. If the provisional licensee is not in substantial compliance with the initial survey, the commissioner shall either: (1) not issue the facility license and terminate the provisional license; or (2) extend the provisional license for a period not to exceed 90 days and apply conditions necessary to bring the facility into substantial compliance. If the provisional licensee is not in substantial compliance with the survey within the time period of the extension or if the provisional licensee does not satisfy the license conditions, the commissioner may deny the license.

Subd. 3. **Reconsideration.** (a) If a provisional licensee whose facility license has been denied or extended with conditions disagrees with the conclusions of the commissioner, then the provisional licensee may request a reconsideration by the commissioner or

commissioner's designee. The reconsideration request process must be conducted internally by the commissioner or designee and chapter 14 does not apply.

(b) The provisional licensee requesting the reconsideration must make the request in writing and must list and describe the reasons why the provisional licensee disagrees with the decision to deny the facility license or the decision to extend the provisional license with conditions.

(c) The reconsideration request and supporting documentation must be received by the commissioner within 15 calendar days after the date the provisional licensee receives the denial or provisional license with conditions.

Subd. 4. **Continued operation.** A provisional licensee whose license is denied is permitted to continue operating during the period of time when:

(1) a reconsideration is in process;

(2) an extension of the provisional license and terms associated with it is in active negotiation between the commissioner and the licensee and the commissioner confirms the negotiation is active; or

(3) a transfer of residents to a new facility is underway and not all of the residents have relocated.

Subd. 5. **Requirements for notice and transfer.** A provisional licensee whose license is denied must comply with the requirements for notification and transfer of residents in section 144J.08.

Subd. 6. **Fines.** The fee for failure to comply with the notification requirements in section 144J.08, subdivision 6, paragraph (b), is $1,000.

Sec. 5. **[144I.04] APPLICATION FOR LICENSURE.**

Subdivision 1. **License applications.** (a) Each application for a facility license, including a provisional license, must include information sufficient to show that the applicant meets the requirements of licensure, including:

(1) the business name and legal entity name of the operating entity; street address and mailing address of the facility; and the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living administrator;

(2) the name and e-mail address of the managing agent, if applicable;

(3) the licensed bed capacity and the license category;

(4) the license fee in the amount specified in section 144.122;

(5) any judgments, private or public litigation, tax liens, written complaints, administrative actions, or investigations by any government agency against the applicant, owner, controlling individual, managerial official, or assisted living administrator that are unresolved or otherwise filed or commenced within the preceding ten years;

(6) documentation of compliance with the background study requirements in section 144I.06 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant;

(7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182;

(8) disclosure that the provider has no liability coverage or, if the provider has coverage, documentation of coverage;

(9) a copy of the executed lease agreement if applicable;

(10) a copy of the management agreement if applicable;

(11) a copy of the operations transfer agreement or similar agreement if applicable;

(12) a copy of the executed agreement if the facility has contracted services with another organization or individual for services such as managerial, billing, consultative, or medical personnel staffing;

(13) a copy of the organizational chart that identifies all organizations and individuals with any ownership interests in the facility;

(14) whether any applicant, owner, controlling individual, managerial official, or assisted living administrator of the facility has ever been convicted of a crime or found civilly liable for an offense involving moral turpitude, including forgery, embezzlement, obtaining money under false pretenses, larceny, extortion, conspiracy to defraud, or any other similar offense or violation; any violation of section 626.557 or any other similar law in any other state; or any violation of a federal or state law or regulation in connection with activities involving any consumer fraud, false advertising, deceptive trade practices, or similar consumer protection law;

(15) whether the applicant or any owner, controlling individual, managerial official, or assisted living administrator of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings;

(16) documentation that the applicant has designated one or more owners, controlling individuals, or employees as an agent or agents, which shall not affect the legal responsibility of any other owner or controlling individual under this chapter;

(17) the signature of the owner or owners, or an authorized agent of the owner or owners of the facility applicant. An application submitted on behalf of a business entity must be signed by at least two owners or controlling individuals;

(18) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, or revoked under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; and

(19) any other information required by the commissioner.

Subd. 2. **Agents.** (a) An application for a facility license or for renewal of a facility license must specify one or more owners, controlling individuals, or employees as agents:

(1) who shall be responsible for dealing with the commissioner on all requirements of this chapter; and

(2) on whom personal service of all notices and orders shall be made and who shall be authorized to accept service on behalf of all of the controlling individuals of the facility in proceedings under this chapter.

(b) Notwithstanding any law to the contrary, personal service on the designated person or persons named in the application is deemed to be service on all of the controlling individuals or managerial employees of the facility and it is not a defense to any action arising under this chapter that personal service was not made on each controlling individual or managerial official of the facility. The designation of one or more controlling individuals or managerial officials under this subdivision shall not affect the legal responsibility of any other controlling individual or managerial official under this chapter.

Subd. 3. **Fees.** (a) An initial applicant, renewal applicant, or applicant filing a change of ownership for assisted living facility licensure must submit the application fee required in section 144I.122 to the commissioner along with a completed application.

(b) The penalty for late submission of the renewal application after expiration of the license is $200. The penalty for operating a facility after expiration of the license and before a renewal license is issued, is $250 each day after expiration of the license until the renewal license issuance date. The facility is still subject to the criminal gross misdemeanor penalties for operating after license expiration.

(c) Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund. All fees are nonrefundable.

(d) Fines collected under this subdivision shall be deposited in a dedicated special revenue account. On an annual basis, the balance in the special revenue account shall be appropriated to the commissioner to implement the recommendations of the advisory council established in section 144A.4799.

Sec. 6. **[144I.05] TRANSFER OF LICENSE PROHIBITED.**

Subdivision 1. **Transfers prohibited.** Any facility license issued by the commissioner may not be transferred to another party.

Subd. 2. **New license required.** (a) Before acquiring ownership of a facility, a prospective applicant must apply for a new license. The licensee of an assisted living facility must change whenever the following events occur, including but not limited to:

(1) the licensee's form of legal organization is changed;

(2) the licensee transfers ownership of the facility business enterprise to another party regardless of whether ownership of some or all of the real property or personal property assets of the assisted living facility is also transferred;

(3) the licensee dissolves, consolidates, or merges with another legal organization and the licensee's legal organization does not survive;

(4) during any continuous 24-month period, 50 percent or more of the licensed entity is transferred, whether by a single transaction or multiple transactions, to:

(i) a different person; or

(ii) a person who had less than a five percent ownership interest in the facility at the time of the first transaction; or

(5) any other event or combination of events that results in a substitution, elimination, or withdrawal of the licensee's control of the facility.

(b) As used in this section, "control" means the possession, directly or indirectly, of the power to direct the management, operation, and policies of the licensee or facility, whether through ownership, voting control, by agreement, by contract, or otherwise.

(c) The current facility licensee must provide written notice to the department and residents, or designated representatives, at least 60 calendar days prior to the anticipated date of the change of licensee.

Subd. 3. **Survey required.** For all new licensees after a change in ownership, the commissioner shall complete a survey within six months after the new license is issued.

Sec. 7. **[144I.06] BACKGROUND STUDIES.**

Subdivision 1. **Background studies required.** (a) Before the commissioner issues a provisional license, issues a license as a result of an approved change of ownership, or renews a license, a controlling individual or managerial official is required to complete a background study under section 144.057. No person may be involved in the management, operation, or control of a facility if the person has been disqualified under chapter 245C. For the purposes of this section, managerial officials subject to the background check requirement are individuals who provide direct contact.

(b) The commissioner shall not issue a license if the controlling individual or managerial official has been unsuccessful in having a background study disqualification set aside under section 144.057 and chapter 245C.

(c) Employees, contractors, and volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this section shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.

Subd. 2. **Reconsideration.** If an individual is disqualified under section 144.057 or chapter 245C, the individual may request reconsideration of the disqualification. If the individual requests reconsideration and the commissioner sets aside or rescinds the disqualification, the individual is eligible to be involved in the management, operation, or control of the facility. If an individual has a disqualification under section 245C.15, subdivision 1, and the disqualification is affirmed, the individual's disqualification is barred from a set aside, and the individual must not be involved in the management, operation, or control of the facility.

Subd. 3. **Data classification.** Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.

Subd. 4. **Termination in good faith.** Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.

Sec. 8. **[144I.07] LICENSE RENEWAL.**

Except as provided in section ....., a license that is not a provisional license may be renewed for a period of up to one year if the licensee satisfies the following:

(1) submits an application for renewal in the format provided by the commissioner at least 60 days before expiration of the license;

(2) submits the renewal fee under section 144I.04, subdivision 3;

(3) submits the late fee under section 144I.04, subdivision 3, if the renewal application is received less than 30 days before the expiration date of the license;

(4) provides information sufficient to show that the applicant meets the requirements of licensure, including items required under section 144I.04, subdivision 1; and

(5) provides any other information deemed necessary by the commissioner.

Sec. 9. **[144I.08] NOTIFICATION OF CHANGES IN INFORMATION.**

A provisional licensee or licensee shall notify the commissioner in writing prior to any financial or contractual change and within 60 calendar days after any change in the information required in section 144I.04, subdivision 1.

Sec. 10. **[144I.09] CONSIDERATION OF APPLICATIONS.**

(a) The commissioner shall consider an applicant's performance history in Minnesota and in other states, including repeat violations or rule violations, before issuing a provisional license, license, or renewal license.

(b) An applicant must not have a history within the last five years in Minnesota or in any other state of a license or certification involuntarily suspended or voluntarily terminated during any enforcement process in a facility that provides care to children, the elderly or ill individuals, or individuals with disabilities.

(c) Failure to provide accurate information or demonstrate required performance history may result in the denial of a license.

(d) The commissioner may deny, revoke, suspend, restrict, or refuse to renew the license or impose conditions if:

(1) the applicant fails to provide complete and accurate information on the application and the commissioner concludes that the missing or corrected information is needed to determine if a license shall be granted;

(2) the applicant, knowingly or with reason to know, made a false statement of a material fact in an application for the license or any data attached to the application or in any matter under investigation by the department;

(3) the applicant refused to allow representatives or agents of the department to inspect its books, records, and files, or any portion of the premises;

(4) willfully prevented, interfered with, or attempted to impede in any way: (i) the work of any authorized representative of the department, the ombudsman for long-term care, or the ombudsman for mental health and developmental disabilities; or (ii) the duties of the commissioner, local law enforcement, city or county attorneys, adult protection, county case managers, or other local government personnel;

(5) the applicant has a history of noncompliance with federal or state regulations that were detrimental to the health, welfare, or safety of a resident or a client; and

(6) the applicant violates any requirement in this chapter.

(e) For all new licensees after a change in ownership, the commissioner shall complete a survey within six months after the new license is issued.

Sec. 11. **[144I.10] MINIMUM ASSISTED LIVING FACILITY REQUIREMENTS.**

Subdivision 1. **Minimum requirements.** All licensed facilities shall:

(1) distribute to residents, families, and resident representatives the assisted living bill of rights in section 144J.02;

(2) provide health-related services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285;

(3) utilize person-centered planning and service delivery process as defined in section 245D.07;

(4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285;

(5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week;

(6) allow residents the ability to furnish and decorate the resident's unit within the terms of the lease;

(7) permit residents access to food at any time;

(8) allow residents to choose the resident's visitors and times of visits;

(9) allow the resident the right to choose a roommate if sharing a unit;

(10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible;

(11) develop and implement a staffing plan for determining its staffing level that:

(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;

(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and

(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;

(12) ensures that a person or persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs, who shall be:

(i) awake;

(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;

(iii) capable of communicating with residents;

(iv) capable of providing or summoning the appropriate assistance; and

(v) capable of following directions. For an assisted living facility providing dementia care, the awake person must be physically present in the locked or secure unit; and

(13) offer to provide or make available at least the following services to residents:

(i) at least three daily nutritious meals with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of

Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:

(A) modified special diets that are appropriate to residents' needs and choices;

(B) menus prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes;

(C) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and

(D) the facility cannot require a resident to include and pay for meals in their contract;

(ii) weekly housekeeping;

(iii) weekly laundry service;

(iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the person or persons responsible for providing this assistance;

(v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about the person or persons responsible for providing this assistance; and

(vi) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large.

Subd. 2. **Policies and procedures.** (a) Each facility must have policies and procedures in place to address the following and keep them current:

(1) requirements in section 626.557, reporting of maltreatment of vulnerable adults;

(2) conducting and handling background studies on employees;

(3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance;

(4) handling complaints from residents, family members, or designated representatives regarding staff or services provided by staff;

(5) conducting initial evaluation of residents' needs and the providers' ability to provide those services;

(6) conducting initial and ongoing resident evaluations and assessments and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate;

(7) orientation to and implementation of the assisted living bill of rights;

(8) infection control practices;

(9) reminders for medications, treatments, or exercises, if provided; and

(10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards.

(b) For assisted living facilities and assisted living facilities with dementia care, the following are also required:

(1) conducting initial and ongoing assessments of the resident's needs by a registered nurse or appropriate licensed health professional, including how changes in the resident's conditions are identified, managed, and communicated to staff and other health care providers, as appropriate;

(2) ensuring that nurses and licensed health professionals have current and valid licenses to practice;

(3) medication and treatment management;

(4) delegation of tasks by registered nurses or licensed health professionals;

(5) supervision of registered nurses and licensed health professionals; and

(6) supervision of unlicensed personnel performing delegated tasks.

Subd. 3. **Infection control program.** The facility shall establish and maintain an infection control program.

Subd. 4. **Clinical nurse supervision.** All assisted living facilities must have a clinical nurse supervisor who is a registered nurse licensed in Minnesota.

Subd. 5. **Resident and family or resident representative councils.** (a) If a resident, family, or designated representative chooses to establish a council, the licensee shall support the council's establishment. The facility must provide assistance and space for meetings and afford privacy. Staff or visitors may attend meetings only upon the council's invitation. A

staff person must be designated the responsibility of providing this assistance and responding to written requests that result from council meetings. Resident council minutes are public data and shall be available to all residents in the facility. Family or resident representatives may attend resident councils upon invitation by a resident on the council.

(b) All assisted living facilities shall engage their residents and families or designated representatives in the operation of their community and document the methods and results of this engagement.

Subd. 6. **Resident grievances.** All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care.

Subd. 7. **Protecting resident rights.** A facility shall ensure that every resident has access to consumer advocacy or legal services by:

(1) providing names and contact information, including telephone numbers and e-mail addresses of at least three organizations that provide advocacy or legal services to residents;

(2) providing the name and contact information for the Minnesota Office of Ombudsman for Long-Term Care and the Office of the Ombudsman for Mental Health and Developmental Disabilities, including both the state and regional contact information;

(3) assisting residents in obtaining information on whether Medicare or medical assistance under chapter 256B will pay for services;

(4) making reasonable accommodations for people who have communication disabilities and those who speak a language other than English; and

(5) providing all information and notices in plain language and in terms the residents can understand.

Subd. 8. **Protection-related rights.** (a) In addition to the rights required in the assisted living bill of rights under section 144J.02, the following rights must be provided to all residents. The facility must promote and protect these rights for each resident by making residents aware of these rights and ensuring staff are trained to support these rights:

(1) the right to furnish and decorate the resident's unit within the terms of the lease;

(2) the right to access food at any time;

(3) the right to choose visitors and the times of visits;

(4) the right to choose a roommate if sharing a unit;

(5) the right to personal privacy including the right to have and use a lockable door on the resident's unit. The facility shall provide the locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible;

(6) the right to engage in chosen activities;

(7) the right to engage in community life;

(8) the right to control personal resources; and

(9) the right to individual autonomy, initiative, and independence in making life choices including a daily schedule and with whom to interact.

(b) The resident's rights in paragraph (a), clauses (2), (3), and (5), may be restricted for an individual resident only if determined necessary for health and safety reasons identified by the facility through an initial assessment or reassessment under section 144I.15, subdivision 9, and documented in the written service plan under section 144I.15, subdivision 10. Any restrictions of those rights for people served under sections 256B.0915 and 256B.49 must be documented by the case manager in the resident's coordinated service and support plan (CSSP), as defined in sections 256B.0915, subdivision 6, and 256B.49, subdivision 15.

Subd. 9. **Payment for services under disability waivers.** For new facilities, home and community-based services under section 256B.49 are not available when the new facility setting is adjoined to, or on the same property as, an institution as defined in Code of Federal Regulations, title 42, section 441.301(c).

Subd. 10. **No discrimination based on source of payment.** All facilities must, regardless of the source of payment and for all persons seeking to reside or residing in the facility:

(1) provide equal access to quality care; and

(2) establish, maintain, and implement identical policies and practices regarding residency, transfer, and provision and termination of services.

**EFFECTIVE DATE.** This section is effective August 1, 2021.

Sec. 12. **[144I.11] FACILITY RESPONSIBILITIES; HOUSING AND SERVICE-RELATED MATTERS.**

Subdivision 1. **Responsibility for housing and services.** The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility.

Subd. 2. **Uniform checklist disclosure of services.** (a) On and after August 1, 2021, a facility must provide to prospective residents, the prospective resident's designated representative, and any other person or persons the resident chooses:

(1) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and

(2) an oral explanation of the services offered under the contract.

(b) The requirements of paragraph (a) must be completed prior to the execution of the resident contract.

(c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a).

Subd. 3. **Reservation of rights.** Nothing in this chapter:

(1) requires a resident to utilize any service provided by or through, or made available in, a facility;

(2) prevents a facility from requiring, as a condition of the contract, that the resident pay for a package of services even if the resident does not choose to use all or some of the services in the package. For residents who are eligible for home and community-based waiver services under sections 256B.0915 and 256B.49, payment for services will follow the policies of those programs;

(3) requires a facility to fundamentally alter the nature of the operations of the facility in order to accommodate a resident's request; or

(4) affects the duty of a facility to grant a resident's request for reasonable accommodations.

Sec. 13. **[144I.12] TRANSFER OF RESIDENTS WITHIN FACILITY.**

(a) A facility must provide for the safe, orderly, and appropriate transfer of residents within the facility.

(b) If an assisted living contract permits resident transfers within the facility, the facility must provide at least 30 days' advance notice of the transfer to the resident and the resident's designated representative.

(c) In situations where there is a curtailment, reduction, capital improvement, or change in operations within a facility, the facility must minimize the number of transfers needed to complete the project or change in operations, consider individual resident needs and preferences, and provide reasonable accommodation for individual resident requests regarding the room transfer. The facility must provide notice to the Office of Ombudsman for Long-Term Care and, when appropriate, the Office of Ombudsman for Mental Health and Developmental Disabilities in advance of any notice to residents, residents' designated representatives, and families when all of the following circumstances apply:

(1) the transfers of residents within the facility are being proposed due to curtailment, reduction, capital improvements, or change in operations;

(2) the transfers of residents within the facility are not temporary moves to accommodate physical plan upgrades or renovation; and

(3) the transfers involve multiple residents being moved simultaneously.

**EFFECTIVE DATE.** This section is effective August 1, 2021.

Sec. 14. **[144I.13] FACILITY RESPONSIBILITIES; BUSINESS OPERATION.**

Subdivision 1. **Display of license.** The original current license must be displayed at the main entrance of the facility. The facility must provide a copy of the license to any person who requests it.

Subd. 2. **Quality management.** The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. The quality management activity means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.

Subd. 3. **Facility restrictions.** (a) This subdivision does not apply to licensees that are Minnesota counties or other units of government.

(b) A facility or staff person cannot accept a power-of-attorney from residents for any purpose, and may not accept appointments as guardians or conservators of residents.

(c) A facility cannot serve as a resident's representative.

Subd. 4. **Handling resident's finances and property.** (a) A facility may assist residents with household budgeting, including paying bills and purchasing household goods, but may not otherwise manage a resident's property. A facility must provide a resident with receipts for all transactions and purchases paid with the resident's funds. When receipts are not available, the transaction or purchase must be documented. A facility must maintain records of all such transactions.

(b) A facility or staff person may not borrow a resident's funds or personal or real property, nor in any way convert a resident's property to the facility's or staff person's possession.

(c) Nothing in this section precludes a facility or staff from accepting gifts of minimal value or precludes the acceptance of donations or bequests made to a facility that are exempt from income tax under section 501(c) of the Internal Revenue Code of 1986.

Subd. 5. **Reporting maltreatment of vulnerable adults; abuse prevention plan.** (a) All facilities must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.

(b) Each facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.

Subd. 6. **Reporting suspected crime and maltreatment.** (a) A facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:

(1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;

(2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center under section 626.557 to report suspected maltreatment of a vulnerable adult; and

(3) providing reasonable accommodations with information and notices in plain language.

Subd. 7. **Employee records.** (a) The facility must maintain current records of each paid employee, regularly scheduled volunteers providing services, and each individual contractor providing services. The records must include the following information:

(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this statute or other rules;

(2) records of orientation, required annual training and infection control training, and competency evaluations;

(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;

(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;

(5) for individuals providing facility services, verification that required health screenings under section 144I.034, subdivision 7, have taken place and the dates of those screenings; and

(6) documentation of the background study as required under section 144.057.

(b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease.

Subd. 8. **Compliance officer.** Every assisted living facility shall have a compliance officer who is a licensed assisted living administrator. An individual licensed as a nursing home administrator, an assisted living administrator, or a health services executive shall automatically meet the qualifications of a compliance officer.

Sec. 15. **[144I.14] FACILITY RESPONSIBILITIES; STAFF.**

Subdivision 1. **Qualifications, training, and competency.** All staff persons providing services must be trained and competent in the provision of services consistent with current practice standards appropriate to the resident's needs and be informed of the assisted living bill of rights under section 144J.02.

Subd. 2. **Licensed health professionals and nurses.** (a) Licensed health professionals and nurses providing services as employees of a licensed facility must possess a current Minnesota license or registration to practice.

(b) Licensed health professionals and registered nurses must be competent in assessing resident needs, planning appropriate services to meet resident needs, implementing services, and supervising staff if assigned.

(c) Nothing in this section limits or expands the rights of nurses or licensed health professionals to provide services within the scope of their licenses or registrations, as provided by law.

Subd. 3. **Unlicensed personnel.** (a) Unlicensed personnel providing services must have:

(1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in subdivision 6, paragraph (b); or

(2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in subdivision 6, paragraph (b); and successfully demonstrated competency of topics in subdivision 6, paragraph (b), clauses (5), (7), and (8), by a practical skills test.

Unlicensed personnel providing basic care services shall not perform delegated nursing or therapy tasks.

(b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must:

(1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in subdivision 6, paragraphs (b) and (c), and a practical skills test on tasks listed in subdivision 6, paragraphs (b), clauses (5) and (7), and (c), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform;

(2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or

(3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner.

(c) Unlicensed personnel performing therapy or treatment tasks delegated or assigned by a licensed health professional must meet the requirements for delegated tasks in subdivision 4 and any other training or competency requirements within the licensed health

professional's scope of practice relating to delegation or assignment of tasks to unlicensed personnel.

Subd. 4. **Delegation of assisted living services.** A registered nurse or licensed health professional may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. The assisted living facility must establish and implement a system to communicate up-to-date information to the registered nurse or licensed health professional regarding the current available staff and their competency so the registered nurse or licensed health professional has sufficient information to determine the appropriateness of delegating tasks to meet individual resident needs and preferences.

Subd. 5. **Temporary staff.** When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility.

Subd. 6. **Requirements for instructors, training content, and competency evaluations for unlicensed personnel.** (a) Instructors and competency evaluators must meet the following requirements:

(1) training and competency evaluations of unlicensed personnel providing basic care services must be conducted by individuals with work experience and training in providing basic care services; and

(2) training and competency evaluations of unlicensed personnel providing comprehensive assisted living services must be conducted by a registered nurse, or another instructor may provide training in conjunction with the registered nurse.

(b) Training and competency evaluations for all unlicensed personnel must include the following:

(1) documentation requirements for all services provided;

(2) reports of changes in the resident's condition to the supervisor designated by the facility;

(3) basic infection control, including blood-borne pathogens;

(4) maintenance of a clean and safe environment;

(5) appropriate and safe techniques in personal hygiene and grooming, including:

(i) hair care and bathing;

(ii) care of teeth, gums, and oral prosthetic devices;

(iii) care and use of hearing aids; and

(iv) dressing and assisting with toileting;

(6) training on the prevention of falls;

(7) standby assistance techniques and how to perform them;

(8) medication, exercise, and treatment reminders;

(9) basic nutrition, meal preparation, food safety, and assistance with eating;

(10) preparation of modified diets as ordered by a licensed health professional;

(11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;

(12) awareness of confidentiality and privacy;

(13) understanding appropriate boundaries between staff and residents and the resident's family;

(14) procedures to use in handling various emergency situations; and

(15) awareness of commonly used health technology equipment and assistive devices.

(c) In addition to paragraph (b), training and competency evaluation for unlicensed personnel providing comprehensive assisted living services must include:

(1) observing, reporting, and documenting resident status;

(2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;

(3) reading and recording temperature, pulse, and respirations of the resident;

(4) recognizing physical, emotional, cognitive, and developmental needs of the resident;

(5) safe transfer techniques and ambulation;

(6) range of motioning and positioning; and

(7) administering medications or treatments as required.

(d) When the registered nurse or licensed health professional delegates tasks, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and are able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24

consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record.

Subd. 7. **Tuberculosis prevention and control.** A facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report (MMWR). The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

Subd. 8. **Disaster planning and emergency preparedness plan.** (a) Each facility must meet the following requirements:

(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;

(2) post an emergency disaster plan prominently;

(3) provide building emergency exit diagrams to all residents;

(4) post emergency exit diagrams on each floor; and

(5) have a written policy and procedure regarding missing tenant residents.

(b) Each facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.

(c) Each facility must meet any additional requirements adopted in rule.

Sec. 16. **[144I.15] FACILITY RESPONSIBILITIES WITH RESPECT TO RESIDENTS.**

Subdivision 1. **Assisted living bill of rights; notification to resident.** (a) A facility shall provide the resident and the designated representative a written notice of the rights under section 144J.02 before the initiation of services to that resident. The facility shall

make all reasonable efforts to provide notice of the rights to the resident and the designated representative in a language the resident and designated representative can understand.

(b) In addition to the text of the bill of rights in section 144J.02, the notice shall also contain the following statement describing how to file a complaint.

"If you want to report suspected maltreatment of a vulnerable adult, you may call the Minnesota Adult Abuse Reporting Center at 1-844-880-1574. If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities."

(c) The statement must include the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint.

(d) A facility must obtain written acknowledgment of the resident's receipt of the bill of rights or shall document why an acknowledgment cannot be obtained. The acknowledgment may be obtained from the resident and the designated representative. Acknowledgment of receipt shall be retained in the resident's record.

Subd. 2. **Notices in plain language; language accommodations.** A facility must provide all notices in plain language that residents can understand and make reasonable accommodations for residents who have communication disabilities and those whose primary language is a language other than English.

Subd. 3. **Notice of services for dementia, Alzheimer's disease, or related disorders.** A facility that provides services to residents with dementia shall provide in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered.

Subd. 4. **Services oversight and information.** A facility shall provide each resident with identifying and contact information about the persons who can assist with health care or supportive services being provided. A facility shall keep each resident informed of changes in the personnel referenced in this subdivision.

Subd. 5. **Notice to residents; change in ownership or management.** A facility must provide prompt written notice to the resident or designated representative of any change of legal name, telephone number, and physical mailing address, which may not be a public or private post office box, of:

(1) the licensee of the facility;

(2) the manager of the facility, if applicable; and

(3) the agent authorized to accept legal process on behalf of the facility.

Subd. 6. **Acceptance of residents.** A facility may not accept a person as a resident unless the facility has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the service plan and that are within the facility's scope of practice.

Subd. 7. **Referrals.** If a facility reasonably believes that a resident is in need of another medical or health service, including a licensed health professional, or social service provider, the facility shall:

(1) determine the resident's preferences with respect to obtaining the service; and

(2) inform the resident of the resources available, if known, to assist the resident in obtaining services.

Subd. 8. **Initiation of services.** When a facility initiates services and the individualized assessment required in subdivision 9 has not been completed, the facility must complete a temporary plan and agreement with the resident for services.

Subd. 9. **Initial assessments and monitoring.** (a) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. The nursing assessment must be completed within five days of the start of services.

(b) Resident reassessment and monitoring must be conducted no more than 14 days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 days from the last date of the assessment.

(c) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment.

(d) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

Subd. 10. **Service plan, implementation, and revisions to service plan.** (a) No later than 14 days after the date that services are first provided, a facility shall finalize a current written service plan.

(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident or the designated representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 9. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care.

(c) The facility must implement and provide all services required by the current service plan.

(d) The service plan and the revised service plan must be entered into the resident's record, including notice of a change in a resident's fees when applicable.

(e) Staff providing services must be informed of the current written service plan.

(f) The service plan must include:

(1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;

(2) the identification of staff or categories of staff who will provide the services;

(3) the schedule and methods of monitoring assessments of the resident;

(4) the schedule and methods of monitoring staff providing services; and

(5) a contingency plan that includes:

(i) the action to be taken by the facility and by the resident and the designated representative if the scheduled service cannot be provided;

(ii) information and a method for a resident and the designated representative to contact the facility;

(iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and

(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.

Subd. 11. **Use of restraints.** Residents of assisted living facilities must be free from any physical or chemical restraints. Restraints are only permissible if determined necessary for health and safety reasons identified by the facility through an initial assessment or reassessment, under subdivision 9, and documented in the written service plan under subdivision 10.

Subd. 12. **Request for discontinuation of life-sustaining treatment.** (a) If a resident, family member, or other caregiver of the resident requests that an employee or other agent of the facility discontinue a life-sustaining treatment, the employee or agent receiving the request:

(1) shall take no action to discontinue the treatment; and

(2) shall promptly inform the supervisor or other agent of the facility of the resident's request.

(b) Upon being informed of a request for discontinuance of treatment, the facility shall promptly:

(1) inform the resident that the request will be made known to the physician or advanced practice registered nurse who ordered the resident's treatment;

(2) inform the physician or advanced practice registered nurse of the resident's request; and

(3) work with the resident and the resident's physician or advanced practice registered nurse to comply with chapter 145C.

(c) This section does not require the facility to discontinue treatment, except as may be required by law or court order.

(d) This section does not diminish the rights of residents to control their treatments, refuse services, or terminate their relationships with the facility.

(e) This section shall be construed in a manner consistent with chapter 145B or 145C, whichever applies, and declarations made by residents under those chapters.

Subd. 13. **Medical cannabis.** Facilities may exercise the authority and are subject to the protections in section 152.34.

Subd. 14. **Landlord and tenant.** Facilities are subject to and must comply with chapter 504B.

Sec. 17. **[144I.16] PROVISION OF SERVICES.**

Subdivision 1. **Availability of contact person to staff.** (a) Assisted living facilities and assisted living facilities that provide dementia care must have a registered nurse available for consultation to staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies.

(b) The appropriate contact person must be readily available either in person, by telephone, or by other means to the staff at times when the staff is providing services.

Subd. 2. **Supervision of staff; basic care services.** (a) Staff who perform basic care services must be supervised periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. The supervision of the unlicensed personnel must be done by staff of the facility having the authority, skills, and ability to provide the supervision of unlicensed personnel and who can implement changes as needed, and train staff.

(b) Supervision includes direct observation of unlicensed personnel while the unlicensed personnel are providing the services and may also include indirect methods of gaining input such as gathering feedback from the resident. Supervisory review of staff must be provided at a frequency based on the staff person's competency and performance.

Subd. 3. **Supervision of staff providing delegated nursing or therapy tasks.** (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse per the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.

(b) The direct supervision of staff performing delegated tasks must be provided within 30 days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.

Subd. 4. **Documentation.** A facility must retain documentation of supervision activities in the personnel records.

Sec. 18. **[144I.17] MEDICATION MANAGEMENT.**

Subdivision 1. **Medication management services.** (a) This section applies only to assisted living facilities that provide medication management services.

(b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines.

(c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and designated representative, if any; disposing of unused medications; and educating residents and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23.

Subd. 2. **Provision of medication management services.** (a) For each resident who requests medication management services, the assisted living facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.

(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and designated representative on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.

Subd. 3. **Individualized medication monitoring and reassessment.** The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually.

Subd. 4. **Resident refusal.** The assisted living facility must document in the resident's record any refusal for an assessment for medication management by the resident. The assisted living facility must discuss with the resident the possible consequences of the resident's refusal and document the discussion in the resident's record.

Subd. 5. **Individualized medication management plan.** (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The assisted living facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:

(1) a statement describing the medication management services that will be provided;

(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;

(3) documentation of specific resident instructions relating to the administration of medications;

(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;

(5) identification of medication management tasks that may be delegated to unlicensed personnel;

(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and

(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.

(b) The medication management record must be current and updated when there are any changes.

(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.

Subd. 6. **Administration of medication.** Medications may be administered by a nurse, physician, or other licensed health practitioner authorized to administer medications or by unlicensed personnel who have been delegated medication administration tasks by a registered nurse.

Subd. 7. **Delegation of medication administration.** When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:

(1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;

(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and

(3) communicated with the unlicensed personnel about the individual needs of the resident.

Subd. 8. **Documentation of administration of medications.** Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.

Subd. 9. **Documentation of medication setup.** Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup.

Subd. 10. **Medication management for residents who will be away from home.** (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that:

(1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice;

(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall give the resident and designated representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;

(3) the resident or designated representative must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances;

(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled; and

(5) the resident and designated representative must be provided in writing the facility's name and information on how to contact the facility.

(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:

(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and

(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:

(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;

(ii) how the container or containers must be labeled;

(iii) written information about the medications to be given to the resident or designated representative;

(iv) how the unlicensed staff must document in the resident's record that medications have been given to the resident and the designated representative, including documenting the date the medications were given to the resident or the designated representative and who received the medications, the person who gave the medications to the resident, the number of medications that were given to the resident, and other required information;

(v) how the registered nurse shall be notified that medications have been given to the resident or designated representative and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;

(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and

(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.

Subd. 11. **Prescribed and nonprescribed medication.** The assisted living facility must determine whether the facility shall require a prescription for all medications the provider manages. The assisted living facility must inform the resident or the designated representative whether the facility requires a prescription for all over-the-counter and dietary supplements before the facility agrees to manage those medications.

Subd. 12. **Medications; over-the-counter drugs; dietary supplements not prescribed.** An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the medications are up to date and stored as appropriate.

Subd. 13. **Prescriptions.** There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident.

Subd. 14. **Renewal of prescriptions.** Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152.

Subd. 15. **Verbal prescription orders.** Verbal prescription orders from an authorized prescriber must be received by a nurse or pharmacist. The order must be handled according to Minnesota Rules, part 6800.6200.

Subd. 16. **Written or electronic prescription.** When a written or electronic prescription is received, it must be communicated to the registered nurse in charge and recorded or placed in the resident's record.

Subd. 17. **Records confidential.** A prescription or order received verbally, in writing, or electronically must be kept confidential according to sections 144.291 to 144.298 and 144A.44.

Subd. 18. **Medications provided by resident or family members.** When the assisted living facility is aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the resident's record.

Subd. 19. **Storage of medications.** An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.

Subd. 20. **Prescription drugs.** A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.

Subd. 21. **Prohibitions.** No prescription drug supply for one resident may be used or saved for use by anyone other than the resident.

Subd. 22. **Disposition of medications.** (a) Any current medications being managed by the assisted living facility must be given to the resident or the designated representative when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be given to the resident or the designated representative for disposal.

(b) The assisted living facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.

(c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as

applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.

Subd. 23. **Loss or spillage.** (a) Assisted living facilities providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the resident's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations.

(b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records.

Sec. 19. **[144I.18] TREATMENT AND THERAPY MANAGEMENT SERVICES.**

Subdivision 1. **Treatment and therapy management services.** This section applies only to assisted living facilities that provide comprehensive assisted living services.

Subd. 2. **Policies and procedures.** (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines.

(b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber.

Subd. 3. **Individualized treatment or therapy management plan.** For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:

(1) a statement of the type of services that will be provided;

(2) documentation of specific resident instructions relating to the treatments or therapy administration;

(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;

(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and

(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.

Subd. 4. **Administration of treatments and therapy.** Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:

(1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures;

(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and

(3) communicated with the unlicensed personnel about the individual needs of the resident.

Subd. 5. **Documentation of administration of treatments and therapies.** Each treatment or therapy administered by an assisted living facility must be in the resident's record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.

Subd. 6. **Treatment and therapy orders.** There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.

Subd. 7. **Right to outside service provider; other payors.** Under section 144J.02, a resident is free to retain therapy and treatment services from an off-site service provider. Assisted living facilities must make every effort to assist residents in obtaining information regarding whether the Medicare program, the medical assistance program under chapter 256B, or another public program will pay for any or all of the services.

Sec. 20. **[144I.19] RESIDENT RECORD REQUIREMENTS.**

Subdivision 1. **Resident record.** (a) The facility must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry.

(b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident's records and establish criteria for release of resident information.

(c) The facility may not disclose to any other person any personal, financial, or medical information about the resident, except:

(1) as may be required by law;

(2) to employees or contractors of the facility, another facility, other health care practitioner or provider, or inpatient facility needing information in order to provide services to the resident, but only the information that is necessary for the provision of services;

(3) to persons authorized in writing by the resident or the resident's representative to receive the information, including third-party payers; and

(4) to representatives of the commissioner authorized to survey or investigate facilities under this chapter or federal laws.

Subd. 2. **Access to records.** The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request.

Subd. 3. **Contents of resident record.** Contents of a resident record include the following for each resident:

(1) identifying information, including the resident's name, date of birth, address, and telephone number;

(2) the name, address, and telephone number of an emergency contact, family members, designated representative, if any, or others as identified;

(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;

(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;

(5) the resident's advance directives, if any;

(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;

(7) the facility's current and previous assessments and service plans;

(8) all records of communications pertinent to the resident's services;

(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;

(10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;

(11) documentation that services have been provided as identified in the service plan;

(12) documentation that the resident has received and reviewed the assisted living bill of rights;

(13) documentation of complaints received and any resolution;

(14) a discharge summary, including service termination notice and related documentation, when applicable; and

(15) other documentation required under this chapter and relevant to the resident's services or status.

Subd. 4. **Transfer of resident records.** If a resident transfers to another facility or another health care practitioner or provider, or is admitted to an inpatient facility, the facility, upon request of the resident or the resident's representative, shall take steps to ensure a coordinated transfer including sending a copy or summary of the resident's record to the new facility or the resident, as appropriate.

Subd. 5. **Record retention.** Following the resident's discharge or termination of services, a facility must retain a resident's record for at least five years or as otherwise required by state or federal regulations. Arrangements must be made for secure storage and retrieval of resident records if the facility ceases to operate.

Sec. 21. **[144I.20] ORIENTATION AND ANNUAL TRAINING REQUIREMENTS.**

Subdivision 1. **Orientation of staff and supervisors.** All staff providing and supervising direct services must complete an orientation to facility licensing requirements and regulations before providing services to residents. The orientation may be incorporated into the training required under subdivision 6. The orientation need only be completed once for each staff person and is not transferable to another facility.

Subd. 2. **Content.** (a) The orientation must contain the following topics:

(1) an overview of this chapter;

(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;

(3) handling of emergencies and use of emergency services;

(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557, including information on the Minnesota Adult Abuse Reporting Center;

(5) assisted living bill of rights under section 144J.02;

(6) protection-related rights under section 144I.10, subdivision 8, and staff responsibilities related to ensuring the exercise and protection of those rights;

(7) the principles of person-centered service planning and delivery and how they apply to direct support services provided by the staff person;

(8) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;

(9) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and

(10) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.

(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:

(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;

(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or

(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

Subd. 3. **Verification and documentation of orientation.** Each facility shall retain evidence in the employee record of each staff person having completed the orientation required by this section.

Subd. 4. **Orientation to resident.** Staff providing services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically.

Subd. 5. **Training required relating to dementia.** All direct care staff and supervisors providing direct services must receive training that includes a current explanation of Alzheimer's disease and related disorders, effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia or related memory disorders.

Subd. 6. **Required annual training.** (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The

training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:

(1) training on reporting of maltreatment of vulnerable adults under section 626.557;

(2) review of the assisted living bill of rights in section 144J.02;

(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;

(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have Alzheimer's disease or related disorders;

(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures;

(6) review of protection-related rights as stated in section 144I.10, subdivision 8, and staff responsibilities related to ensuring the exercise and protection of those rights; and

(7) the principles of person-centered service planning and delivery and how they apply to direct support services provided by the staff person.

(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:

(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;

(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or

(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

Subd. 7. **Documentation.** A facility must retain documentation in the employee records of staff who have satisfied the orientation and training requirements of this section.

Subd. 8. **Implementation.** A facility must implement all orientation and training topics covered in this section.

Sec. 22. **[144I.21] TRAINING IN DEMENTIA CARE REQUIRED.**

(a) Assisted living facilities and assisted living facilities with dementia care must meet the following training requirements:

(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;

(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;

(3) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and

(4) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months.

(b) Areas of required training include:

(1) an explanation of Alzheimer's disease and related disorders;

(2) assistance with activities of daily living;

(3) problem solving with challenging behaviors; and

(4) communication skills.

(c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.

Sec. 23. **[144I.22] CONTROLLING INDIVIDUAL RESTRICTIONS.**

Subdivision 1. **Restrictions.** The controlling individual of a facility may not include any person who was a controlling individual of any other nursing home, assisted living facility, or assisted living facility with dementia care during any period of time in the previous two-year period:

(1) during which time of control the nursing home, assisted living facility, or assisted living facility with dementia care incurred the following number of uncorrected or repeated violations:

(i) two or more uncorrected violations or one or more repeated violations that created an imminent risk to direct resident care or safety; or

(ii) four or more uncorrected violations or two or more repeated violations of any nature, including Level 2, Level 3, and Level 4 violations as defined in section 144I.31; or

(2) who, during that period, was convicted of a felony or gross misdemeanor that relates to the operation of the nursing home, assisted living facility, or assisted living facility with dementia care, or directly affects resident safety or care.

Subd. 2. **Exception.** Subdivision 1 does not apply to any controlling individual of the facility who had no legal authority to affect or change decisions related to the operation of the nursing home, assisted living facility, or assisted living facility with dementia care that incurred the uncorrected violations.

Subd. 3. **Stay of adverse action required by controlling individual restrictions.** (a) In lieu of revoking, suspending, or refusing to renew the license of a facility where a controlling individual was disqualified by subdivision 1, clause (1), the commissioner may issue an order staying the revocation, suspension, or nonrenewal of the facility's license. The order may but need not be contingent upon the facility's compliance with restrictions and conditions imposed on the license to ensure the proper operation of the facility and to protect the health, safety, comfort, treatment, and well-being of the residents in the facility. The decision to issue an order for a stay must be made within 90 days of the commissioner's determination that a controlling individual of the facility is disqualified by subdivision 1, clause (1), from operating a facility.

(b) In determining whether to issue a stay and to impose conditions and restrictions, the commissioner must consider the following factors:

(1) the ability of the controlling individual to operate other facilities in accordance with the licensure rules and laws;

(2) the conditions in the nursing home, assisted living facility, or assisted living facility with dementia care that received the number and type of uncorrected or repeated violations described in subdivision 1, clause (1); and

(3) the conditions and compliance history of each of the nursing homes, assisted living facilities, and assisted living facilities with dementia care owned or operated by the controlling individuals.

(c) The commissioner's decision to exercise the authority under this subdivision in lieu of revoking, suspending, or refusing to renew the license of the facility is not subject to administrative or judicial review.

(d) The order for the stay of revocation, suspension, or nonrenewal of the facility license must include any conditions and restrictions on the license that the commissioner deems necessary based on the factors listed in paragraph (b).

(e) Prior to issuing an order for stay of revocation, suspension, or nonrenewal, the commissioner shall inform the controlling individual in writing of any conditions and restrictions that will be imposed. The controlling individual shall, within ten working days, notify the commissioner in writing of a decision to accept or reject the conditions and restrictions. If the facility rejects any of the conditions and restrictions, the commissioner must either modify the conditions and restrictions or take action to suspend, revoke, or not renew the facility's license.

(f) Upon issuance of the order for a stay of revocation, suspension, or nonrenewal, the controlling individual shall be responsible for compliance with the conditions and restrictions. Any time after the conditions and restrictions have been in place for 180 days, the controlling individual may petition the commissioner for removal or modification of the conditions and restrictions. The commissioner must respond to the petition within 30 days of receipt of the written petition. If the commissioner denies the petition, the controlling individual may request a hearing under the provisions of chapter 14. Any hearing shall be limited to a determination of whether the conditions and restrictions shall be modified or removed. At the hearing, the controlling individual bears the burden of proof.

(g) The failure of the controlling individual to comply with the conditions and restrictions contained in the order for stay shall result in the immediate removal of the stay and the commissioner shall take action to suspend, revoke, or not renew the license.

(h) The conditions and restrictions are effective for two years after the date they are imposed.

(i) Nothing in this subdivision shall be construed to limit in any way the commissioner's ability to impose other sanctions against a facility licensee under the standards in state or federal law whether or not a stay of revocation, suspension, or nonrenewal is issued.

Sec. 24. **[144I.23] MANAGEMENT AGREEMENTS; GENERAL REQUIREMENTS.**

Subdivision 1. **Notification.** (a) If the proposed or current licensee uses a manager, the licensee must have a written management agreement that is consistent with this chapter.

(b) The proposed or current licensee must notify the commissioner of its use of a manager upon:

(1) initial application for a license;

(2) retention of a manager following initial application;

(3) change of managers; and

(4) modification of an existing management agreement.

(c) The proposed or current licensee must provide to the commissioner a written management agreement, including an organizational chart showing the relationship between the proposed or current licensee, management company, and all related organizations.

(d) The written management agreement must be submitted:

(1) 60 days before:

(i) the initial licensure date;

(ii) the proposed change of ownership date; or

(iii) the effective date of the management agreement; or

(2) 30 days before the effective date of any amendment to an existing management agreement.

(e) The proposed licensee or the current licensee must notify the residents and their representatives 60 days before entering into a new management agreement.

(f) A proposed licensee must submit a management agreement.

Subd. 2. **Management agreement; licensee.** (a) The licensee is legally responsible for:

(1) the daily operations and provisions of services in the facility;

(2) ensuring the facility is operated in a manner consistent with all applicable laws and rules;

(3) ensuring the manager acts in conformance with the management agreement; and

(4) ensuring the manager does not present as, or give the appearance that the manager is the licensee.

(b) The licensee must not give the manager responsibilities that are so extensive that the licensee is relieved of daily responsibility for the daily operations and provision of services in the assisted living facility. If the licensee does so, the commissioner must determine that a change of ownership has occurred.

(c) The licensee and manager must act in accordance with the terms of the management agreement. If the commissioner determines they are not, then the department may impose enforcement remedies.

(d) The licensee may enter into a management agreement only if the management agreement creates a principal/agent relationship between the licensee and manager.

(e) The manager shall not subcontract the manager's responsibilities to a third party.

Subd. 3. **Terms of agreement.** A management agreement at a minimum must:

(1) describe the responsibilities of the licensee and manager, including items, services, and activities to be provided;

(2) require the licensee's governing body, board of directors, or similar authority to appoint the administrator;

(3) provide for the maintenance and retention of all records in accordance with this chapter and other applicable laws;

(4) allow unlimited access by the commissioner to documentation and records according to applicable laws or regulations;

(5) require the manager to immediately send copies of inspections and notices of noncompliance to the licensee;

(6) state that the licensee is responsible for reviewing, acknowledging, and signing all facility initial and renewal license applications;

(7) state that the manager and licensee shall review the management agreement annually and notify the commissioner of any change according to applicable regulations;

(8) acknowledge that the licensee is the party responsible for complying with all laws and rules applicable to the facility;

(9) require the licensee to maintain ultimate responsibility over personnel issues relating to the operation of the facility and care of the residents including but not limited to staffing plans, hiring, and performance management of employees, orientation, and training;

(10) state the manager will not present as, or give the appearance that the manager is the licensee; and

(11) state that a duly authorized manager may execute resident leases or agreements on behalf of the licensee, but all such resident leases or agreements must be between the licensee and the resident.

Subd. 4. **Commissioner review.** The commissioner may review a management agreement at any time. Following the review, the department may require:

(1) the proposed or current licensee or manager to provide additional information or clarification;

(2) any changes necessary to:

(i) bring the management agreement into compliance with this chapter; and

(ii) ensure that the licensee has not been relieved of the legal responsibility for the daily operations of the facility; and

(3) the licensee to participate in monthly meetings and quarterly on-site visits to the facility.

Subd. 5. **Resident funds.** (a) If the management agreement delegates day-to-day management of resident funds to the manager, the licensee:

(1) retains all fiduciary and custodial responsibility for funds that have been deposited with the facility by the resident;

(2) is directly accountable to the resident for such funds; and

(3) must ensure any party responsible for holding or managing residents' personal funds is bonded or obtains insurance in sufficient amounts to specifically cover losses of resident funds and provides proof of bond or insurance.

(b) If responsibilities for the day-to-day management of the resident funds are delegated to the manager, the manager must:

(1) provide the licensee with a monthly accounting of the resident funds; and

(2) meet all legal requirements related to holding and accounting for resident funds.

Sec. 25. **[144I.24] MINIMUM SITE, PHYSICAL ENVIRONMENT, AND FIRE SAFETY REQUIREMENTS.**

Subdivision 1. **Requirements.** (a) Effective August 1, 2021, the following are required for all assisted living facilities and assisted living facilities with dementia care:

(1) public utilities must be available, and working or inspected and approved water and septic systems are in place;

(2) the location is publicly accessible to fire department services and emergency medical services;

(3) the location's topography provides sufficient natural drainage and is not subject to flooding;

(4) all-weather roads and walks must be provided within the lot lines to the primary entrance and the service entrance, including employees' and visitors' parking at the site; and

(5) the location must include space for outdoor activities for residents.

(b) An assisted living facility with a dementia care unit must also meet the following requirements:

(1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and

(2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.

Subd. 2. **Fire protection and physical environment.** (a) Effective December 31, 2019, each assisted living facility and assisted living facility with dementia care must have a comprehensive fire protection system that includes:

(1) protection throughout by an approved supervised automatic sprinkler system according to building code requirements established in Minnesota Rules, part 1305.0903, or smoke detectors in each occupied room installed and maintained in accordance with the National Fire Protection Association (NFPA) Standard 72;

(2) portable fire extinguishers installed and tested in accordance with the NFPA Standard 10; and

(3) the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.

(b) Beginning August 1, 2021, fire drills shall be conducted in accordance with the residential board and care requirements in the Life Safety Code.

Subd. 3. **Local laws apply.** Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements.

Subd. 4. **Assisted living facilities; design.** (a) After July 31, 2021, all assisted living facilities with six or more residents must meet the provisions relevant to assisted living facilities of the most current edition of the Facility Guidelines Institute "Guidelines for Design and Construction of Residential Health, Care and Support Facilities" and of adopted rules. This minimum design standard shall be met for all new licenses, new construction, modifications, renovations, alterations, change of use, or additions. In addition to the guidelines, assisted living facilities, and assisted living facilities with dementia care shall provide the option of a bath in addition to a shower for all residents.

(b) The commissioner shall establish an implementation timeline for mandatory usage of the latest published guidelines. However, the commissioner shall not enforce the latest published guidelines before six months after the date of publication.

Subd. 5. **Assisted living facilities; life safety code.** (a) After August 1, 2021, all assisted living facilities with six or more residents shall meet the applicable provisions of the most current edition of the NFPA Standard 101, Life Safety Code, Residential Board and Care Occupancies chapter. This minimum design standard shall be met for all new licenses, new construction, modifications, renovations, alterations, change of use, or additions.

(b) The commissioner shall establish an implementation timeline for mandatory usage of the latest published Life Safety Code. However, the commissioner shall not enforce the latest published guidelines before six months after the date of publication.

Subd. 6. **Assisted living facilities with dementia care units; life safety code.** (a) Beginning August 1, 2021, all assisted living facilities with dementia care units shall meet the applicable provisions of the most current edition of the NFPA Standard 101, Life Safety

Code, Healthcare (limited care) chapter. This minimum design standard shall be met for all new licenses, new construction, modifications, renovations, alterations, change of use or additions.

(b) The commissioner shall establish an implementation timeline for mandatory usage of the newest-published Life Safety Code. However, the commissioner shall not enforce the newly-published guidelines before 6 months after the date of publication.

Subd. 7. **New construction; plans.** (a) For all new licensure and construction beginning on or after August 1, 2021, the following must be provided to the commissioner:

(1) architectural and engineering plans and specifications for new construction must be prepared and signed by architects and engineers who are registered in Minnesota. Final working drawings and specifications for proposed construction must be submitted to the commissioner for review and approval;

(2) final architectural plans and specifications must include elevations and sections through the building showing types of construction, and must indicate dimensions and assignments of rooms and areas, room finishes, door types and hardware, elevations and details of nurses' work areas, utility rooms, toilet and bathing areas, and large-scale layouts of dietary and laundry areas. Plans must show the location of fixed equipment and sections and details of elevators, chutes, and other conveying systems. Fire walls and smoke partitions must be indicated. The roof plan must show all mechanical installations. The site plan must indicate the proposed and existing buildings, topography, roadways, walks and utility service lines; and

(3) final mechanical and electrical plans and specifications must address the complete layout and type of all installations, systems, and equipment to be provided. Heating plans must include heating elements, piping, thermostatic controls, pumps, tanks, heat exchangers, boilers, breeching and accessories. Ventilation plans must include room air quantities, ducts, fire and smoke dampers, exhaust fans, humidifiers, and air handling units. Plumbing plans must include the fixtures and equipment fixture schedule; water supply and circulating piping, pumps, tanks, riser diagrams, and building drains; the size, location, and elevation of water and sewer services; and the building fire protection systems. Electrical plans must include fixtures and equipment, receptacles, switches, power outlets, circuits, power and light panels, transformers, and service feeders. Plans must show location of nurse call signals, cable lines, fire alarm stations, and fire detectors and emergency lighting.

(b) Unless construction is begun within one year after approval of the final working drawing and specifications, the drawings must be resubmitted for review and approval.

(c) The commissioner must be notified within 30 days before completion of construction so that the commissioner can make arrangements for a final inspection by the commissioner.

(d) At least one set of complete life safety plans, including changes resulting from remodeling or alterations, must be kept on file in the facility.

Subd. 8. **Variances or waivers.** (a) A facility may request that the commissioner grant a variance or waiver from the provisions of this section. A request for a waiver must be submitted to the commissioner in writing. Each request must contain:

(1) the specific requirement for which the variance or waiver is requested;

(2) the reasons for the request;

(3) the alternative measures that will be taken if a variance or waiver is granted;

(4) the length of time for which the variance or waiver is requested; and

(5) other relevant information deemed necessary by the commissioner to properly evaluate the request for the waiver.

(b) The decision to grant or deny a variance or waiver must be based on the commissioner's evaluation of the following criteria:

(1) whether the waiver will adversely affect the health, treatment, comfort, safety, or well-being of a patient;

(2) whether the alternative measures to be taken, if any, are equivalent to or superior to those prescribed in this section; and

(3) whether compliance with the requirements would impose an undue burden on the applicant.

(c) The commissioner must notify the applicant in writing of the decision. If a variance or waiver is granted, the notification must specify the period of time for which the variance or waiver is effective and the alternative measures or conditions, if any, to be met by the applicant.

(d) Alternative measures or conditions attached to a variance or waiver have the force and effect of this chapter and are subject to the issuance of correction orders and fines in accordance with sections 144I.30, subdivision 7, and 144I.31. The amount of fines for a violation of this section is that specified for the specific requirement for which the variance or waiver was requested.

(e) A request for the renewal of a variance or waiver must be submitted in writing at least 45 days before its expiration date. Renewal requests must contain the information specified in paragraph (b). A variance or waiver must be renewed by the department if the applicant continues to satisfy the criteria in paragraph (a) and demonstrates compliance with the alternative measures or conditions imposed at the time the original variance or waiver was granted.

(f) The department must deny, revoke, or refuse to renew a variance or waiver if it is determined that the criteria in paragraph (a) are not met. The applicant must be notified in writing of the reasons for the decision and informed of the right to appeal the decision.

(g) An applicant may contest the denial, revocation, or refusal to renew a variance or waiver by requesting a contested case hearing under chapter 14. The applicant must submit, within 15 days of the receipt of the department's decision, a written request for a hearing. The request for hearing must set forth in detail the reasons why the applicant contends the decision of the department should be reversed or modified. At the hearing, the applicant has the burden of proving by a preponderance of the evidence that the applicant satisfied the criteria specified in paragraph (b), except in a proceeding challenging the revocation of a variance or waiver.

Sec. 26. **[144I.25] RESIDENCY AND SERVICES CONTRACT REQUIREMENTS.**

Subdivision 1. **Contract required.** (a) An assisted living facility or assisted living facility with dementia care may not offer or provide housing or services to a resident unless it has executed a written contract with the resident.

(b) The contract must:

(1) be signed by both:

(i) the resident or the designated representative; and

(ii) the licensee or an agent of the facility; and

(2) contain all the terms concerning the provision of:

(i) housing; and

(ii) services, whether provided directly by the facility or by management agreement.

(c) A facility must:

(1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and

(2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident or the designated representative promptly after a contract and any addendum has been signed by the resident or the designated representative.

(d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.

(e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated or resident representative or both in writing in the contract. The contract must contain a page or space for the name and contact information of the designated or resident representative or both and a box the resident must initial if the resident declines to name a designated or resident representative. Notwithstanding paragraph (f), the resident has the right at any time to rescind the declination or add or change the name and contact information of the designated or resident representative.

(f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident or resident's designated representative and the facility, a new contract or an addendum to the existing contract must be executed and signed.

Subd. 2. **Contents and contract; contact information.** (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility.

(b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:

(1) the facility and contracted service provider when applicable;

(2) the licensee of the facility;

(3) the managing agent of the facility, if applicable; and

(4) at least one natural person who is authorized to accept service of process on behalf of the facility.

(c) The contract must include:

(1) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing and/or services to be provided for the contracted amount;

(2) a delineation of the cost and nature of any other services to be provided for an additional fee;

(3) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract;

(4) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; and

(5) billing and payment procedures and requirements.

(d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints.

(e) The contract must include a clear and conspicuous notice of:

(1) the right under section 144J.09 to challenge a discharge, eviction, or transfer or service termination;

(2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and whether or not consent of the resident being asked to transfer is required;

(3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;

(4) the resident's right to obtain services from an unaffiliated service provider;

(5) a description of the assisted living facility's policies related to medical assistance waivers under sections 256B.0915 and 256B.49, including:

(i) whether the provider is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers;

(ii) whether there is a limit on the number of people residing at the assisted living facility who can receive customized living services at any point in time. If so, the limit must be provided;

(iii) whether the assisted living facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers, and if so, the length of time that private payment is required;

(iv) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent;

(v) a statement that residents may be eligible for assistance with rent through the housing support program; and

(vi) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program;

(6) the contact information to obtain long-term care consulting services under section 256B.0911; and

(7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.

(f) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints.

Subd. 3. **Additional contract requirements.** (a) A restriction of a resident's rights under this subdivision is allowed only if determined necessary for health and safety reasons identified by the facility's registered nurse in an initial assessment or reassessment, under section 144I.15, subdivision 9, and documented in the written service plan under section 144I.15, subdivision 10. Any restrictions of those rights for individuals served under sections 256B.0915 and 256B.49 must be documented in the resident's coordinated service and support plan (CSSP), as defined under sections 256B.0915, subdivision 6, and 256B.49, subdivision 15.

(b) The contract must include a statement:

(1) regarding the ability of a resident to furnish and decorate the resident's unit within the terms of the lease;

(2) regarding the resident's right to access food at any time;

(3) regarding a resident's right to choose the resident's visitors and times of visits;

(4) regarding the resident's right to choose a roommate if sharing a unit; and

(5) notifying the resident of the resident's right to have and use a lockable door to the resident's unit. The landlord shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible.

Subd. 4. **Filing.** The contract and related documents executed by each resident or the designated representative must be maintained by the facility in files from the date of execution until three years after the contract is terminated or expires. The contracts and all associated

documents will be available for on-site inspection by the commissioner at any time. The documents shall be available for viewing or copies shall be made available to the resident and the designated representative at any time.

Subd. 5. **Waivers of liability prohibited.** The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.

Sec. 27. **[144I.27] PLANNED CLOSURES.**

Subdivision 1. **Closure plan required.** In the event that a facility elects to voluntarily close the facility, the facility must notify the commissioner and the Office of Ombudsman for Long-Term Care in writing by submitting a proposed closure plan.

Subd. 2. **Content of closure plan.** The facility's proposed closure plan must include:

(1) the procedures and actions the facility will implement to notify residents of the closure, including a copy of the written notice to be given to residents, designated representatives, resident representatives, or family;

(2) the procedures and actions the facility will implement to ensure all residents receive appropriate termination planning in accordance with section 144J.10, subdivisions 1 to 6, and final accountings and returns under section 144J.10, subdivision 7;

(3) assessments of the needs and preferences of individual residents; and

(4) procedures and actions the facility will implement to maintain compliance with this chapter until all residents have relocated.

Subd. 3. **Commissioner's approval required prior to implementation.** (a) The plan shall be subject to the commissioner's approval and subdivision 6. The facility shall take no action to close the residence prior to the commissioner's approval of the plan. The commissioner shall approve or otherwise respond to the plan as soon as practicable.

(b) The commissioner of health may require the facility to work with a transitional team comprised of department staff, staff of the Office of Ombudsman for Long-Term Care, and other professionals the commissioner deems necessary to assist in the proper relocation of residents.

Subd. 4. **Termination planning and final accounting requirements.** Prior to termination, the facility must follow the termination planning requirements under section

144J.10, subdivisions 1 to 6, and final accounting and return requirements under section 144J.10, subdivision 7, for residents. The facility must implement the plan approved by the commissioner and ensure that arrangements for relocation and continued care that meet each resident's social, emotional, and health needs are effectuated prior to closure.

Subd. 5. **Notice to residents.** After the commissioner has approved the relocation plan and at least 60 calendar days before closing, except as provided under subdivision 6, the facility must notify residents, designated representatives, and resident representatives or, if a resident has no designated representative or resident representative, a family member, if known, of the closure, the proposed date of closure, the contact information of the ombudsman for long-term care, and that the facility will follow the termination planning requirements under section 144J.10, subdivisions 1 to 6, and final accounting and return requirements under section 144J.10, subdivision 7.

Subd. 6. **Emergency closures.** (a) In the event the facility must close because the commissioner deems the facility can no longer remain open, the facility must meet all requirements in subdivisions 1 to 5, except for any requirements the commissioner finds would endanger the health and safety of residents. In the event the commissioner determines a closure must occur with less than 60 calendar days' notice, the facility shall provide notice to residents as soon as practicable or as directed by the commissioner.

(b) Upon request from the commissioner, a facility must provide the commissioner with any documentation related to the appropriateness of its relocation plan, or to any assertion that the facility lacks the funds to comply with subdivision 1 to 5, or that remaining open would otherwise endanger the health and safety of residents pursuant to paragraph (a).

Subd. 7. **Other rights.** Nothing in this section or section 144J.08 or 144J.10 affects the rights and remedies available under chapter 504B, except to the extent those rights or remedies are inconsistent with this section.

Subd. 8. **Fine.** The commissioner may impose a fine for failure to follow the requirements of this section or section 144J.08 or 144J.10.

Sec. 28. **[144I.28] RELOCATIONS WITHIN ASSISTED LIVING LOCATION.**

Subdivision 1. **Notice required before relocation within location.** (a) A facility must:

(1) notify a resident and the resident's representative, if any, at least 14 calendar days prior to a proposed nonemergency relocation to a different room at the same location; and

(2) obtain consent from the resident and the resident's representative, if any.

(b) A resident must be allowed to stay in the resident's room. If a resident consents to a move, any needed reasonable modifications must be made to the new room to accommodate the resident's disabilities.

Subd. 2. **Evaluation.** A facility shall evaluate the resident's individual needs before deciding whether the room the resident will be moved to fits the resident's psychological, cognitive, and health care needs, including the accessibility of the bathroom.

Subd. 3. **Restriction on relocation.** A person who has been a private-pay resident for at least one year and resides in a private room, and whose payments subsequently will be made under the medical assistance program under chapter 256B, may not be relocated to a shared room without the consent of the resident or the resident's representative, if any.

**EFFECTIVE DATE.** This section is effective August 1, 2021.

Sec. 29. **[144I.29] COMMISSIONER OVERSIGHT AND AUTHORITY.**

Subdivision 1. **Regulations.** The commissioner shall regulate facilities pursuant to this chapter. The regulations shall include the following:

(1) provisions to assure, to the extent possible, the health, safety, well-being, and appropriate treatment of residents while respecting individual autonomy and choice;

(2) requirements that facilities furnish the commissioner with specified information necessary to implement this chapter;

(3) standards of training of facility personnel;

(4) standards for provision of services;

(5) standards for medication management;

(6) standards for supervision of services;

(7) standards for resident evaluation or assessment;

(8) standards for treatments and therapies;

(9) requirements for the involvement of a resident's health care provider, the documentation of the health care provider's orders, if required, and the resident's service plan;

(10) the maintenance of accurate, current resident records;

(11) the establishment of levels of licenses based on services provided; and

(12) provisions to enforce these regulations and the assisted living bill of rights.

Subd. 2. **Regulatory functions.** (a) The commissioner shall:

(1) license, survey, and monitor without advance notice facilities in accordance with this chapter;

(2) survey every provisional licensee within one year of the provisional license issuance date subject to the provisional licensee providing licensed services to residents;

(3) survey facility licensees annually;

(4) investigate complaints of facilities;

(5) issue correction orders and assess civil penalties;

(6) take action as authorized in section 144I.33; and

(7) take other action reasonably required to accomplish the purposes of this chapter.

(b) Beginning August 1, 2021, the commissioner shall review blueprints for all new facility construction and must approve the plans before construction may be commenced.

(c) The commissioner shall provide on-site review of the construction to ensure that all physical environment standards are met before the facility license is complete.

Sec. 30. **[144I.30] SURVEYS AND INVESTIGATIONS.**

Subdivision 1. **Regulatory powers.** (a) The Department of Health is the exclusive state agency charged with the responsibility and duty of surveying and investigating all facilities required to be licensed under this chapter. The commissioner of health shall enforce all sections of this chapter and the rules adopted under this chapter.

(b) The commissioner, upon request of the facility, must be given access to relevant information, records, incident reports, and other documents in the possession of the facility if the commissioner considers them necessary for the discharge of responsibilities. For purposes of surveys and investigations and securing information to determine compliance with licensure laws and rules, the commissioner need not present a release, waiver, or consent to the individual. The identities of residents must be kept private as defined in section 13.02, subdivision 12.

Subd. 2. **Surveys.** The commissioner shall conduct surveys of each assisted living facility and assisted living facility with dementia care. The commissioner shall conduct a survey of each facility on a frequency of at least once each year. The commissioner may conduct surveys more frequently than once a year based on the license level, the provider's compliance history, the number of clients served, or other factors as determined by the department

deemed necessary to ensure the health, safety, and welfare of residents and compliance with the law.

Subd. 3. **Follow-up surveys.** The commissioner may conduct follow-up surveys to determine if the facility has corrected deficient issues and systems identified during a survey or complaint investigation. Follow-up surveys may be conducted via phone, e-mail, fax, mail, or onsite reviews. Follow-up surveys, other than complaint investigations, shall be concluded with an exit conference and written information provided on the process for requesting a reconsideration of the survey results.

Subd. 4. **Scheduling surveys.** Surveys and investigations shall be conducted without advance notice to the facilities. Surveyors may contact the facility on the day of a survey to arrange for someone to be available at the survey site. The contact does not constitute advance notice. The surveyor must provide presurvey notification to the Office of Ombudsman for Long-Term Care.

Subd. 5. **Information provided by facility.** The facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities.

Subd. 6. **Providing resident records.** Upon request of a surveyor, facilities shall provide a list of current and past residents or designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents within a reasonable period of time.

Subd. 7. **Correction orders.** (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the provider is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction.

(b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically.

(c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed.

Subd. 8. **Required follow-up surveys.** For facilities that have Level 3 or Level 4 violations under section 144I.31, the department shall conduct a follow-up survey within 90 calendar days of the survey. When conducting a follow-up survey, the surveyor shall focus on whether the previous violations have been corrected and may also address any new violations that are observed while evaluating the corrections that have been made.

Sec. 31. **[144I.31] VIOLATIONS AND FINES.**

Subdivision 1. **Fine amounts.** (a) Fines and enforcement actions under this subdivision may be assessed based on the level and scope of the violations described in subdivision 2 as follows and imposed immediately with no opportunity to correct the violation prior to imposition:

(1) Level 1, no fines or enforcement;

(2) Level 2, a fine of $500 per violation;

(3) Level 3, a fine of $3,000 per violation per incident plus $100 for each resident affected by the violation;

(4) Level 4, a fine of $5,000 per incident plus $200 for each resident; and

(5) for maltreatment violations as defined in the Minnesota Vulnerable Adults Act in section 626.557 including abuse, neglect, financial exploitation, and drug diversion that are determined against the facility, an immediate fine shall be imposed of $5,000 per incident, plus $200 for each resident affected by the violation.

Subd. 2. **Level and scope of violation.** Correction orders for violations are categorized by both level and scope, and fines shall be assessed as follows:

(1) level of violation:

(i) Level 1 is a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety;

(ii) Level 2 is a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death;

(iii) Level 3 is a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death; and

(iv) Level 4 is a violation that results in serious injury, impairment, or death; and

(2) scope of violation:

(i) isolated, when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally;

(ii) pattern, when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive; and

(iii) widespread, when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents.

Subd. 3. **Notice of noncompliance.** If the commissioner finds that the applicant or a facility has not corrected violations by the date specified in the correction order or conditional license resulting from a survey or complaint investigation, the commissioner shall provide a notice of noncompliance with a correction order by e-mailing the notice of noncompliance to the facility. The noncompliance notice must list the violations not corrected.

Subd. 4. **Immediate fine; payment.** (a) For every violation, the commissioner may issue an immediate fine. The licensee must still correct the violation in the time specified. The issuance of an immediate fine may occur in addition to any enforcement mechanism authorized under section 144I.33. The immediate fine may be appealed as allowed under this section.

(b) The licensee must pay the fines assessed on or before the payment date specified. If the licensee fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the licensee complies by paying the fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(c) A licensee shall promptly notify the commissioner in writing when a violation specified in the order is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order, the commissioner may issue an additional fine. The commissioner shall notify the licensee by mail to the last known address in the licensing record that a second fine has been assessed. The licensee may appeal the second fine as provided under this subdivision.

(d) A facility that has been assessed a fine under this section has a right to a reconsideration or hearing under this section and chapter 14.

Subd. 5. **Facility cannot avoid payment.** When a fine has been assessed, the licensee may not avoid payment by closing, selling, or otherwise transferring the license to a third party. In such an event, the licensee shall be liable for payment of the fine.

Subd. 6. **Additional penalties.** In addition to any fine imposed under this section, the commissioner may assess a penalty amount based on costs related to an investigation that results in a final order assessing a fine or other enforcement action authorized by this chapter.

Subd. 7. **Deposit of fines.** Fines collected under this section shall be deposited in the state government special revenue fund and credited to an account separate from the revenue collected under section 144A.472. Subject to an appropriation by the legislature, the revenue from the fines collected must be used by the commissioner for special projects to improve home care in Minnesota as recommended by the advisory council established in section 144A.4799.

Sec. 32. **[144I.32] RECONSIDERATION OF CORRECTION ORDERS AND FINES.**

Subdivision 1. **Reconsideration process required.** The commissioner shall make available to facilities a correction order reconsideration process. This process may be used to challenge the correction order issued, including the level and scope described in section 144I.31, and any fine assessed. When a licensee requests reconsideration of a correction order, the correction order is not stayed while it is under reconsideration. The department shall post information on its website that the licensee requested reconsideration of the correction order and that the review is pending.

Subd. 2. **Reconsideration process.** A facility may request from the commissioner, in writing, a correction order reconsideration regarding any correction order issued to the facility. The written request for reconsideration must be received by the commissioner within 15 calendar days of the correction order receipt date. The correction order reconsideration shall not be reviewed by any surveyor, investigator, or supervisor that participated in writing or reviewing the correction order being disputed. The correction order reconsiderations may be conducted in person, by telephone, by another electronic form, or in writing, as determined by the commissioner. The commissioner shall respond in writing to the request from a facility for a correction order reconsideration within 60 days of the date the facility requests a reconsideration. The commissioner's response shall identify the commissioner's decision regarding each citation challenged by the facility.

Subd. 3. **Findings.** The findings of a correction order reconsideration process shall be one or more of the following:

(1) supported in full: the correction order is supported in full, with no deletion of findings to the citation;

(2) supported in substance: the correction order is supported, but one or more findings are deleted or modified without any change in the citation;

(3) correction order cited an incorrect licensing requirement: the correction order is amended by changing the correction order to the appropriate statute and/or rule;

(4) correction order was issued under an incorrect citation: the correction order is amended to be issued under the more appropriate correction order citation;

(5) the correction order is rescinded;

(6) fine is amended: it is determined that the fine assigned to the correction order was applied incorrectly; or

(7) the level or scope of the citation is modified based on the reconsideration.

Subd. 4. **Updating the correction order website.** If the correction order findings are changed by the commissioner, the commissioner shall update the correction order website.

Subd. 5. **Provisional licensees.** This section does not apply to provisional licensees.

Sec. 33. **[144I.33] ENFORCEMENT.**

Subdivision 1. **Conditions.** (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility or assisted living facility with dementia care:

(1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules;

(2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services;

(3) performs any act detrimental to the health, safety, and welfare of a resident;

(4) obtains the license by fraud or misrepresentation;

(5) knowingly made or makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;

(6) denies representatives of the department access to any part of the facility's books, records, files, or employees;

(7) interferes with or impedes a representative of the department in contacting the facility's residents;

(8) interferes with or impedes a representative of the department in the enforcement of this chapter or has failed to fully cooperate with an inspection, survey, or investigation by the department;

(9) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;

(10) refuses to initiate a background study under section 144.057 or 245A.04;

(11) fails to timely pay any fines assessed by the commissioner;

(12) violates any local, city, or township ordinance relating to housing or services;

(13) has repeated incidents of personnel performing services beyond their competency level; or

(14) has operated beyond the scope of the facility's license category.

(b) A violation by a contractor providing the services of the facility is a violation by facility.

Subd. 2. **Terms to suspension or conditional license.** (a) A suspension or conditional license designation may include terms that must be completed or met before a suspension or conditional license designation is lifted. A conditional license designation may include restrictions or conditions that are imposed on the facility. Terms for a suspension or conditional license may include one or more of the following and the scope of each will be determined by the commissioner:

(1) requiring a consultant to review, evaluate, and make recommended changes to the facility's practices and submit reports to the commissioner at the cost of the facility;

(2) requiring supervision of the facility or staff practices at the cost of the facility by an unrelated person who has sufficient knowledge and qualifications to oversee the practices and who will submit reports to the commissioner;

(3) requiring the facility or employees to obtain training at the cost of the facility;

(4) requiring the facility to submit reports to the commissioner;

(5) prohibiting the facility from admitting any new residents for a specified period of time; or

(6) any other action reasonably required to accomplish the purpose of this subdivision and subdivision 1.

(b) A facility subject to this subdivision may continue operating during the period of time residents are being transferred to another service provider.

Subd. 3. **Immediate temporary suspension.** (a) In addition to any other remedies provided by law, the commissioner may, without a prior contested case hearing, immediately temporarily suspend a license or prohibit delivery of housing or services by a facility for not more than 90 calendar days or issue a conditional license, if the commissioner determines that there are:

(1) Level 4 violations; or

(2) violations that pose an imminent risk of harm to the health or safety of residents.

(b) For purposes of this subdivision, "Level 4" has the meaning given in section 144I.31.

(c) A notice stating the reasons for the immediate temporary suspension or conditional license and informing the licensee of the right to an expedited hearing under subdivision 11 must be delivered by personal service to the address shown on the application or the last known address of the licensee. The licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the licensee receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the licensee received the order.

(d) A licensee whose license is immediately temporarily suspended must comply with the requirements for notification and transfer of residents in subdivision 9. The requirements in subdivision 9 remain if an appeal is requested.

Subd. 4. **Mandatory revocation.** Notwithstanding the provisions of subdivision 7, paragraph (a), the commissioner must revoke a license if a controlling individual of the facility is convicted of a felony or gross misdemeanor that relates to operation of the facility or directly affects resident safety or care. The commissioner shall notify the facility and the Office of Ombudsman for Long-Term Care 30 calendar days in advance of the date of revocation.

Subd. 5. **Mandatory proceedings.** (a) The commissioner must initiate proceedings within 60 calendar days of notification to suspend or revoke a facility's license or must

refuse to renew a facility's license if within the preceding two years the facility has incurred the following number of uncorrected or repeated violations:

(1) two or more uncorrected violations or one or more repeated violations that created an imminent risk to direct resident care or safety; or

(2) four or more uncorrected violations or two or more repeated violations of any nature for which the fines are in the four highest daily fine categories prescribed in rule.

(b) Notwithstanding paragraph (a), the commissioner is not required to revoke, suspend, or refuse to renew a facility's license if the facility corrects the violation.

Subd. 6. **Notice to residents.** (a) Within five business days after proceedings are initiated by the commissioner to revoke or suspend a facility's license, or a decision by the commissioner not to renew a living facility's license, the controlling individual of the facility or a designee must provide to the commissioner and the ombudsman for long-term care the names of residents and the names and addresses of the residents' guardians, designated representatives, and family contacts.

(b) The controlling individual or designees of the facility must provide updated information each month until the proceeding is concluded. If the controlling individual or designee of the facility fails to provide the information within this time, the facility is subject to the issuance of:

(1) a correction order; and

(2) a penalty assessment by the commissioner in rule.

(c) Notwithstanding subdivisions 16 and 17, any correction order issued under this subdivision must require that the facility immediately comply with the request for information and that, as of the date of the issuance of the correction order, the facility shall forfeit to the state a $500 fine the first day of noncompliance and an increase in the $500 fine by $100 increments for each day the noncompliance continues.

(d) Information provided under this subdivision may be used by the commissioner or the ombudsman for long-term care only for the purpose of providing affected consumers information about the status of the proceedings.

(e) Within ten business days after the commissioner initiates proceedings to revoke, suspend, or not renew a facility license, the commissioner must send a written notice of the action and the process involved to each resident of the facility and the resident's designated representative or, if there is no designated representative and if known, a family member or interested person.

(f) The commissioner shall provide the ombudsman for long-term care with monthly information on the department's actions and the status of the proceedings.

Subd. 7. **Notice to facility.** (a) Prior to any suspension, revocation, or refusal to renew a license, the facility shall be entitled to notice and a hearing as provided by sections 14.57 to 14.69. The hearing must commence within 60 calendar days after the proceedings are initiated. In addition to any other remedy provided by law, the commissioner may, without a prior contested case hearing, temporarily suspend a license or prohibit delivery of services by a provider for not more than 90 calendar days, or issue a conditional license if the commissioner determines that there are Level 3 violations that do not pose an imminent risk of harm to the health or safety of the facility residents, provided:

(1) advance notice is given to the facility;

(2) after notice, the facility fails to correct the problem;

(3) the commissioner has reason to believe that other administrative remedies are not likely to be effective; and

(4) there is an opportunity for a contested case hearing within 30 calendar days unless there is an extension granted by an administrative law judge.

(b) If the commissioner determines there are Level 4 violations or violations that pose an imminent risk of harm to the health or safety of the facility residents, the commissioner may immediately temporarily suspend a license, prohibit delivery of services by a facility, or issue a conditional license without meeting the requirements of paragraph (a), clauses (1) to (4).

For the purposes of this subdivision, "Level 3" and "Level 4" have the meanings given in section 144I.31.

Subd. 8. **Request for hearing.** A request for hearing must be in writing and must:

(1) be mailed or delivered to the commissioner or the commissioner's designee;

(2) contain a brief and plain statement describing every matter or issue contested; and

(3) contain a brief and plain statement of any new matter that the applicant or assisted living facility believes constitutes a defense or mitigating factor.

Subd. 9. **Plan required.** (a) The process of suspending, revoking, or refusing to renew a license must include a plan for transferring affected residents' cares to other providers by the facility that will be monitored by the commissioner. Within three calendar days of being notified of the final revocation, refusal to renew, or suspension, the licensee shall provide

the commissioner, the lead agencies as defined in section 256B.0911, county adult protection and case managers, and the ombudsman for long-term care with the following information:

(1) a list of all residents, including full names and all contact information on file;

(2) a list of each resident's representative or emergency contact person, including full names and all contact information on file;

(3) the location or current residence of each resident;

(4) the payor sources for each resident, including payor source identification numbers; and

(5) for each resident, a copy of the resident's service plan and a list of the types of services being provided.

(b) The revocation, refusal to renew, or suspension notification requirement is satisfied by mailing the notice to the address in the license record. The licensee shall cooperate with the commissioner and the lead agencies, county adult protection and county managers, and the ombudsman for long-term care during the process of transferring care of residents to qualified providers. Within three calendar days of being notified of the final revocation, refusal to renew, or suspension action, the facility must notify and disclose to each of the residents, or the resident's representative or emergency contact persons, that the commissioner is taking action against the facility's license by providing a copy of the revocation or suspension notice issued by the commissioner. If the facility does not comply with the disclosure requirements in this section, the commissioner shall notify the residents, designated representatives, or emergency contact persons about the actions being taken. Lead agencies, county adult protection and county managers, and the Office of Ombudsman for Long-Term Care may also provide this information. The revocation, refusal to renew, or suspension notice is public data except for any private data contained therein.

(c) A facility subject to this subdivision may continue operating while residents are being transferred to other service providers.

Subd. 10. **Hearing.** Within 15 business days of receipt of the licensee's timely appeal of a sanction under this section, other than for a temporary suspension, the commissioner shall request assignment of an administrative law judge. The commissioner's request must include a proposed date, time, and place of hearing. A hearing must be conducted by an administrative law judge pursuant to Minnesota Rules, parts 1400.8505 to 1400.8612, within 90 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause or for purposes of discussing

settlement. In no case shall one or more extensions be granted for a total of more than 90 calendar days unless there is a criminal action pending against the licensee. If, while a licensee continues to operate pending an appeal of an order for revocation, suspension, or refusal to renew a license, the commissioner identifies one or more new violations of law that meet the requirements of Level 3 or Level 4 violations as defined in section 144I.31, the commissioner shall act immediately to temporarily suspend the license.

Subd. 11. **Expedited hearing.** (a) Within five business days of receipt of the licensee's timely appeal of a temporary suspension or issuance of a conditional license, the commissioner shall request assignment of an administrative law judge. The request must include a proposed date, time, and place of a hearing. A hearing must be conducted by an administrative law judge pursuant to Minnesota Rules, parts 1400.8505 to 1400.8612, within 30 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause. The commissioner shall issue a notice of hearing by certified mail or personal service at least ten business days before the hearing. Certified mail to the last known address is sufficient. The scope of the hearing shall be limited solely to the issue of whether the temporary suspension or issuance of a conditional license should remain in effect and whether there is sufficient evidence to conclude that the licensee's actions or failure to comply with applicable laws are Level 3 or Level 4 violations as defined in section 144I.31, or that there were violations that posed an imminent risk of harm to the resident's health and safety.

(b) The administrative law judge shall issue findings of fact, conclusions, and a recommendation within ten business days from the date of hearing. The parties shall have ten calendar days to submit exceptions to the administrative law judge's report. The record shall close at the end of the ten-day period for submission of exceptions. The commissioner's final order shall be issued within ten business days from the close of the record. When an appeal of a temporary immediate suspension or conditional license is withdrawn or dismissed, the commissioner shall issue a final order affirming the temporary immediate suspension or conditional license within ten calendar days of the commissioner's receipt of the withdrawal or dismissal. The licensee is prohibited from operation during the temporary suspension period.

(c) When the final order under paragraph (b) affirms an immediate suspension, and a final licensing sanction is issued under subdivisions 1 and 2 and the licensee appeals that sanction, the licensee is prohibited from operation pending a final commissioner's order after the contested case hearing conducted under chapter 14.

(d) A licensee whose license is temporarily suspended must comply with the requirements for notification and transfer of residents under subdivision 9. These requirements remain if an appeal is requested.

Subd. 12. **Time limits for appeals.** To appeal the assessment of civil penalties under section 144I.31, and an action against a license under this section, a licensee must request a hearing no later than 15 business days after the licensee receives notice of the action.

Subd. 13. **Owners and managerial officials; refusal to grant license.** (a) The owner and managerial officials of a facility whose Minnesota license has not been renewed or that has been revoked because of noncompliance with applicable laws or rules shall not be eligible to apply for nor will be granted an assisted living facility license or an assisted living facility with dementia care license, or be given status as an enrolled personal care assistance provider agency or personal care assistant by the Department of Human Services under section 256B.0659, for five years following the effective date of the nonrenewal or revocation. If the owner and/or managerial officials already have enrollment status, the enrollment will be terminated by the Department of Human Services.

(b) The commissioner shall not issue a license to a facility for five years following the effective date of license nonrenewal or revocation if the owner or managerial official, including any individual who was an owner or managerial official of another licensed provider, had a Minnesota license that was not renewed or was revoked as described in paragraph (a).

(c) Notwithstanding subdivision 1, the commissioner shall not renew, or shall suspend or revoke, the license of a facility that includes any individual as an owner or managerial official who was an owner or managerial official of a facility whose Minnesota license was not renewed or was revoked as described in paragraph (a) for five years following the effective date of the nonrenewal or revocation.

(d) The commissioner shall notify the facility 30 calendar days in advance of the date of nonrenewal, suspension, or revocation of the license. Within ten business days after the receipt of the notification, the facility may request, in writing, that the commissioner stay the nonrenewal, revocation, or suspension of the license. The facility shall specify the reasons for requesting the stay; the steps that will be taken to attain or maintain compliance with the licensure laws and regulations; any limits on the authority or responsibility of the owners or managerial officials whose actions resulted in the notice of nonrenewal, revocation, or suspension; and any other information to establish that the continuing affiliation with these individuals will not jeopardize resident health, safety, or well-being. The commissioner

shall determine whether the stay will be granted within 30 calendar days of receiving the facility's request. The commissioner may propose additional restrictions or limitations on the facility's license and require that granting the stay be contingent upon compliance with those provisions. The commissioner shall take into consideration the following factors when determining whether the stay should be granted:

(1) the threat that continued involvement of the owners and managerial officials with the facility poses to resident health, safety, and well-being;

(2) the compliance history of the facility; and

(3) the appropriateness of any limits suggested by the facility.

If the commissioner grants the stay, the order shall include any restrictions or limitation on the provider's license. The failure of the facility to comply with any restrictions or limitations shall result in the immediate removal of the stay and the commissioner shall take immediate action to suspend, revoke, or not renew the license.

Subd. 14. **Relicensing.** If a facility license is revoked, a new application for license may be considered by the commissioner when the conditions upon which the revocation was based have been corrected and satisfactory evidence of this fact has been furnished to the commissioner. A new license may be granted after an inspection has been made and the facility has complied with all provisions of this chapter and adopted rules.

Subd. 15. **Informal conference.** At any time, the applicant or facility and the commissioner may hold an informal conference to exchange information, clarify issues, or resolve issues.

Subd. 16. **Injunctive relief.** In addition to any other remedy provided by law, the commissioner may bring an action in district court to enjoin a person who is involved in the management, operation, or control of a facility or an employee of the facility from illegally engaging in activities regulated by sections under this chapter. The commissioner may bring an action under this subdivision in the district court in Ramsey County or in the district in which the facility is located. The court may grant a temporary restraining order in the proceeding if continued activity by the person who is involved in the management, operation, or control of a facility, or by an employee of the facility, would create an imminent risk of harm to a resident.

Subd. 17. **Subpoena.** In matters pending before the commissioner under this chapter, the commissioner may issue subpoenas and compel the attendance of witnesses and the production of all necessary papers, books, records, documents, and other evidentiary material.

If a person fails or refuses to comply with a subpoena or order of the commissioner to appear or testify regarding any matter about which the person may be lawfully questioned or to produce any papers, books, records, documents, or evidentiary materials in the matter to be heard, the commissioner may apply to the district court in any district, and the court shall order the person to comply with the commissioner's order or subpoena. The commissioner of health may administer oaths to witnesses or take their affirmation. Depositions may be taken in or outside the state in the manner provided by law for taking depositions in civil actions. A subpoena or other process or paper may be served on a named person anywhere in the state by an officer authorized to serve subpoenas in civil actions, with the same fees and mileage and in the same manner as prescribed by law for a process issued out of a district court. A person subpoenaed under this subdivision shall receive the same fees, mileage, and other costs that are paid in proceedings in district court.

Sec. 34. **[144I.34] INNOVATION VARIANCE.**

Subdivision 1. **Definition; granting variances.** (a) For purposes of this section, "innovation variance" means a specified alternative to a requirement of this chapter.

(b) An innovation variance may be granted to allow a facility to offer services of a type or in a manner that is innovative, will not impair the services provided, will not adversely affect the health, safety, or welfare of the residents, and is likely to improve the services provided. The innovative variance cannot change any of the resident's rights under the assisted living bill of rights under section 144J.02.

Subd. 2. **Conditions.** The commissioner may impose conditions on granting an innovation variance that the commissioner considers necessary.

Subd. 3. **Duration and renewal.** The commissioner may limit the duration of any innovation variance and may renew a limited innovation variance.

Subd. 4. **Applications; innovation variance.** An application for innovation variance from the requirements of this chapter may be made at any time, must be made in writing to the commissioner, and must specify the following:

(1) the statute or rule from which the innovation variance is requested;

(2) the time period for which the innovation variance is requested;

(3) the specific alternative action that the licensee proposes;

(4) the reasons for the request; and

(5) justification that an innovation variance will not impair the services provided, will not adversely affect the health, safety, or welfare of residents, and is likely to improve the services provided.

The commissioner may require additional information from the facility before acting on the request.

Subd. 5. **Grants and denials.** The commissioner shall grant or deny each request for an innovation variance in writing within 45 days of receipt of a complete request. Notice of a denial shall contain the reasons for the denial. The terms of a requested innovation variance may be modified upon agreement between the commissioner and the facility.

Subd. 6. **Violation of innovation variances.** A failure to comply with the terms of an innovation variance shall be deemed to be a violation of this chapter.

Subd. 7. **Revocation or denial of renewal.** The commissioner shall revoke or deny renewal of an innovation variance if:

(1) it is determined that the innovation variance is adversely affecting the health, safety, or welfare of the residents;

(2) the facility has failed to comply with the terms of the innovation variance;

(3) the facility notifies the commissioner in writing that it wishes to relinquish the innovation variance and be subject to the statute previously varied; or

(4) the revocation or denial is required by a change in law.

Sec. 35. **[144I.35] RESIDENT QUALITY OF CARE AND OUTCOMES IMPROVEMENT TASK FORCE.**

Subdivision 1. **Establishment.** The commissioner shall establish a resident quality of care and outcomes improvement task force to examine and make recommendations, on an ongoing basis, on how to apply proven safety and quality improvement practices and infrastructure to settings and providers that provide long-term services and supports.

Subd. 2. **Membership.** The task force shall include representation from:

(1) nonprofit Minnesota-based organizations dedicated to patient safety or innovation in health care safety and quality;

(2) Department of Health staff with expertise in issues related to safety and adverse health events;

(3) consumer organizations;

(4) direct care providers or their representatives;

(5) organizations representing long-term care providers and home care providers in Minnesota;

(6) the ombudsman for long-term care or a designee;

(7) national patient safety experts; and

(8) other experts in the safety and quality improvement field.

The task force shall have at least one public member who either is or has been a resident in an assisted living setting and one public member who has or had a family member living in an assisted living setting. The membership shall be voluntary except that public members may be reimbursed under section 15.059, subdivision 3.

Subd. 3. **Recommendations.** The task force shall periodically provide recommendations to the commissioner and the legislature on changes needed to promote safety and quality improvement practices in long-term care settings and with long-term care providers. The task force shall meet no fewer than four times per year. The task force shall be established by July 1, 2020.

Sec. 36. **[144I.36] EXPEDITED RULEMAKING AUTHORIZED.**

(a) The commissioner shall adopt rules for all assisted living facilities that promote person-centered planning and service and optimal quality of life, and that ensure resident rights are protected, resident choice is allowed, and public health and safety is ensured.

(b) On July 1, 2019, the commissioner shall begin expedited rulemaking using the process in section 14.389, except that the rulemaking process is exempt from section 14.389, subdivision 5.

(c) The commissioner shall adopt rules that include but are not limited to the following:

(1) staffing minimums and ratios for each level of licensure to best protect the health and safety of residents no matter their vulnerability;

(2) training prerequisites and ongoing training for administrators and caregiving staff;

(3) requirements for licensees to ensure minimum nutrition and dietary standards required by section 144I.10 are provided;

(4) procedures for discharge planning and ensuring resident appeal rights;

(5) core dementia care requirements and training in all levels of licensure;

(6) requirements for assisted living facilities with dementia care in terms of training, care standards, noticing changes of condition, assessments, and health care;

(7) preadmission criteria, initial assessments, and continuing assessments;

(8) emergency disaster and preparedness plans;

(9) uniform checklist disclosure of services;

(10) uniform consumer information guide elements and other data collected; and

(11) uniform assessment tool.

(d) The commissioner shall publish the proposed rules by December 31, 2019, and shall publish final rules by December 31, 2020.

Sec. 37. **TRANSITION PERIOD.**

(a) From July 1, 2019, to June 30, 2020, the commissioner shall engage in the expedited rulemaking process.

(b) From July 1, 2020, to July 31, 2021, the commissioner shall prepare for the new assisted living facility and assisted living facility with dementia care licensure by hiring staff, developing forms, and communicating with stakeholders about the new facility licensing.

(c) Effective August 1, 2021, all existing housing with services establishments providing home care services under Minnesota Statutes, chapter 144A, must convert their registration to licensure under Minnesota Statutes, chapter 144I.

(d) Effective August 1, 2021, all new assisted living facilities and assisted living facilities with dementia care must be licensed by the commissioner.

(e) Effective August 1, 2021, all assisted living facilities and assisted living facilities with dementia care must be licensed by the commissioner.

Sec. 38. **REPEALER.**

Minnesota Statutes 2018, sections 144D.01; 144D.015; 144D.02; 144D.025; 144D.03; 144D.04; 144D.045; 144D.05; 144D.06; 144D.065; 144D.066; 144D.07; 144D.08; 144D.09; 144D.10; 144D.11; 144G.01; 144G.02; 144G.03; 144G.04; 144G.05; and 144G.06, are repealed effective August 1, 2021.

# ARTICLE 17

## DEMENTIA CARE SERVICES FOR ASSISTED LIVING FACILITIES WITH DEMENTIA CARE

Section 1. **[144I.37] ADDITIONAL REQUIREMENTS FOR ASSISTED LIVING FACILITIES WITH DEMENTIA CARE.**

Subdivision 1. **Applicability.** This section applies only to assisted living facilities with dementia care.

Subd. 2. **Demonstrated capacity.** (a) The applicant must have the ability to provide services in a manner that is consistent with the requirements in this section. The commissioner shall consider the following criteria, including, but not limited to:

(1) the experience of the applicant in managing residents with dementia or previous long-term care experience; and

(2) the compliance history of the applicant in the operation of any care facility licensed, certified, or registered under federal or state law.

(b) If the applicant does not have experience in managing residents with dementia, the applicant must employ a consultant for at least the first six months of operation. The consultant must meet the requirements in paragraph (a), clause (1), and make recommendations on providing dementia care services consistent with the requirements of this chapter. The consultant must have experience in dementia care operations. The applicant must implement the recommendations of the consultant and document an acceptable plan which may be reviewed by the commissioner upon request to address the consultant's identified concerns. The commissioner may review and approve the selection of the consultant.

(c) The commissioner shall conduct an on-site inspection prior to the issuance of an assisted living facility with dementia care license to ensure compliance with the physical environment requirements.

(d) The label "Assisted Living Facility with Dementia Care" must be identified on the license.

Subd. 3. **Relinquishing license.** The licensee must notify the commissioner in writing at least 60 calendar days prior to the voluntary relinquishment of an assisted living facility with dementia care license. For voluntary relinquishment, the facility must:

(1) give all residents and their designated representatives 45 calendar days' notice. The notice must include:

(i) the proposed effective date of the relinquishment;

(ii) changes in staffing;

(iii) changes in services including the elimination or addition of services; and

(iv) staff training that shall occur when the relinquishment becomes effective;

(2) submit a transitional plan to the commissioner demonstrating how the current residents shall be evaluated and assessed to reside in other housing settings that are not an assisted living facility with dementia care, that are physically unsecured, or that would require move-out or transfer to other settings;

(3) change service or care plans as appropriate to address any needs the residents may have with the transition;

(4) notify the commissioner when the relinquishment process has been completed; and

(5) revise advertising materials and disclosure information to remove any reference that the facility is an assisted living facility with dementia care.

Sec. 2. **[144I.38] RESPONSIBILITIES OF ADMINISTRATION FOR ASSISTED LIVING FACILITIES WITH DEMENTIA CARE.**

Subdivision 1. **General.** The licensee of an assisted living facility with dementia care is responsible for the care and housing of the persons with dementia and the provision of person-centered care that promotes each resident's dignity, independence, and comfort. This includes the supervision, training, and overall conduct of the staff.

Subd. 2. **Additional requirements.** (a) The licensee must follow the assisted living license requirements and the criteria in this section.

(b) The administrator of an assisted living facility with dementia care license must complete and document that at least ten hours of the required annual continuing educational requirements relate to the care of individuals with dementia. Continuing education credits must be obtained through commissioner-approved sources that may include college courses, preceptor credits, self-directed activities, course instructor credits, corporate training, in-service training, professional association training, web-based training, correspondence courses, telecourses, seminars, and workshops.

Subd. 3. **Policies.** (a) In addition to the policies and procedures required in the licensing of assisted living facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the:

(1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented;

(2) evaluation of behavioral symptoms and design of supports for intervention plans;

(3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;

(4) assessment of residents for the use and effects of medications, including psychotropic medications;

(5) staff training specific to dementia care;

(6) description of life enrichment programs and how activities are implemented;

(7) description of family support programs and efforts to keep the family engaged;

(8) limiting the use of public address and intercom systems for emergencies and evacuation drills only;

(9) transportation coordination and assistance to and from outside medical appointments; and

(10) safekeeping of resident's possessions.

(b) The policies and procedures must be provided to residents and the resident's representative at the time of move-in.

Sec. 3. **[144I.39] STAFFING AND STAFF TRAINING.**

Subdivision 1. **General.** (a) An assisted living facility with dementia care must provide residents with dementia-trained staff who have been instructed in the person-centered care approach. All direct care and other community staff assigned to care for dementia residents must be specially trained to work with residents with Alzheimer's disease and other dementias.

(b) Only staff trained as specified in subdivisions 2 and 3 shall be assigned to care for dementia residents.

(c) Staffing levels must be sufficient to meet the scheduled and unscheduled needs of residents. Staffing levels during nighttime hours shall be based on the sleep patterns and needs of residents.

(d) In an emergency situation when trained staff are not available to provide services, the facility may assign staff who have not completed the required training. The particular emergency situation must be documented and must address:

(1) the nature of the emergency;

(2) how long the emergency lasted; and

(3) the names and positions of staff that provided coverage.

Subd. 2. **Staffing requirements.** (a) The licensee must ensure that staff who provide support to residents with dementia have a basic understanding and fundamental knowledge of the residents' emotional and unique health care needs using person-centered planning delivery. Direct care dementia-trained staff and other staff must be trained on the topics identified during the expedited rulemaking process. These requirements are in addition to the licensing requirements for training.

(b) Failure to comply with paragraph (a) or subdivision 1 will result in a fine under section 144I.31.

Subd. 3. **Supervising staff training.** Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia.

Subd. 4. **Preservice and in-service training.** Preservice and in-service training may include various methods of instruction, such as classroom style, web-based training, video, or one-to-one training. The licensee must have a method for determining and documenting each staff person's knowledge and understanding of the training provided. All training must be documented.

Sec. 4. **[144I.40] SERVICES FOR RESIDENTS WITH DEMENTIA.**

Subdivision 1. **Dementia care services.** (a) In addition to the minimum services required of assisted living facilities, an assisted living facility with dementia care must also provide the following services:

(1) assistance with activities of daily living that address the needs of each resident with dementia due to cognitive or physical limitations. These services must meet or be in addition to the requirements in the licensing rules for the facility. Services must be provided in a person-centered manner that promotes resident choice, dignity, and sustains the resident's abilities;

(2) health care services provided according to the licensing statutes and rules of the facility;

(3) a daily meal program for nutrition and hydration must be provided and available throughout each resident's waking hours. The individualized nutritional plan for each resident must be documented in the resident's service or care plan. In addition, an assisted living facility with dementia care must provide meaningful activities that promote or help sustain the physical and emotional well-being of residents. The activities must be person-directed and available during residents' waking hours.

(b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:

(1) past and current interests;

(2) current abilities and skills;

(3) emotional and social needs and patterns;

(4) physical abilities and limitations;

(5) adaptations necessary for the resident to participate; and

(6) identification of activities for behavioral interventions.

(c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.

(d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:

(1) occupation or chore related tasks;

(2) scheduled and planned events such as entertainment or outings;

(3) spontaneous activities for enjoyment or those that may help defuse a behavior;

(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;

(5) spiritual, creative, and intellectual activities;

(6) sensory stimulation activities;

(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and

(8) outdoor activities.

(e) Behavioral symptoms that negatively impact the resident and others in the assisted living facility must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated.

(f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly.

(g) Access to secured outdoor space and walkways that allow residents to enter and return without staff assistance must be provided.

## ARTICLE 18
## ASSISTED LIVING LICENSURE CONFORMING CHANGES

Section 1. Minnesota Statutes 2018, section 144.051, subdivision 4, is amended to read:

Subd. 4. **Data classification; public data.** For providers regulated pursuant to sections 144A.43 to 144A.482 and chapter 1444I, the following data collected, created, or maintained by the commissioner are classified as public data as defined in section 13.02, subdivision 15:

(1) all application data on licensees, license numbers, and license status;

(2) licensing information about licenses previously held under this chapter;

(3) correction orders, including information about compliance with the order and whether the fine was paid;

(4) final enforcement actions pursuant to chapter 14;

(5) orders for hearing, findings of fact, and conclusions of law; and

(6) when the licensee and department agree to resolve the matter without a hearing, the agreement and specific reasons for the agreement are public data.

Sec. 2. Minnesota Statutes 2018, section 144.051, subdivision 5, is amended to read:

Subd. 5. **Data classification; confidential data.** For providers regulated pursuant to sections 144A.43 to 144A.482 and chapter 144I, the following data collected, created, or maintained by the Department of Health are classified as confidential data on individuals as defined in section 13.02, subdivision 3: active investigative data relating to the investigation of potential violations of law by a licensee including data from the survey process before the correction order is issued by the department.

Sec. 3. Minnesota Statutes 2018, section 144.051, subdivision 6, is amended to read:

Subd. 6. **Release of private or confidential data.** For providers regulated pursuant to sections 144A.43 to 144A.482 and chapter 144I, the department may release private or confidential data, except Social Security numbers, to the appropriate state, federal, or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, Office of the Ombudsman for Long-Term Care and Office of the Ombudsman for Mental Health and Developmental Disabilities, the health licensing boards, Department of Human Services, county or city attorney's offices, police, and local or county public health offices.

Sec. 4. Minnesota Statutes 2018, section 144.057, subdivision 1, is amended to read:

Subdivision 1. **Background studies required.** The commissioner of health shall contract with the commissioner of human services to conduct background studies of:

(1) individuals providing services ~~which~~ that have direct contact, as defined under section 245C.02, subdivision 11, with patients and residents in hospitals, boarding care homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and home care agencies licensed under chapter 144A; ~~residential care homes licensed under chapter 144B,~~ assisted living facilities, and assisted living facilities with dementia care licensed under chapter 144I, and board and lodging establishments that are registered to provide supportive or health supervision services under section 157.17;

(2) individuals specified in section 245C.03, subdivision 1, who perform direct contact services in a nursing home, assisted living facilities, and assisted living facilities with dementia care licensed under chapter 144I, or a home care agency licensed under chapter 144A or a boarding care home licensed under sections 144.50 to 144.58. If the individual under study resides outside Minnesota, the study must include a check for substantiated findings of maltreatment of adults and children in the individual's state of residence when the information is made available by that state, and must include a check of the National Crime Information Center database;

(3) ~~beginning July 1, 1999,~~ all other employees in assisted living facilities licensed under chapter 144I, nursing homes licensed under chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of an individual in this section shall disqualify the individual from positions allowing direct contact or access to patients or residents receiving services. "Access" means physical access to a client or the client's personal property without continuous, direct supervision as defined in section 245C.02,

subdivision 8, when the employee's employment responsibilities do not include providing direct contact services;

(4) individuals employed by a supplemental nursing services agency, as defined under section 144A.70, who are providing services in health care facilities; and

(5) controlling persons of a supplemental nursing services agency, as defined under section 144A.70.

If a facility or program is licensed by the Department of Human Services and subject to the background study provisions of chapter 245C and is also licensed by the Department of Health, the Department of Human Services is solely responsible for the background studies of individuals in the jointly licensed programs.

Sec. 5. Minnesota Statutes 2018, section 144A.04, subdivision 5, is amended to read:

Subd. 5. **Administrators.** ~~(a)~~ Each nursing home must employ an administrator who must be licensed or permitted as a nursing home administrator by the Board of ~~Examiners for Nursing Home Administrators~~ Executives for Long Term Services and Supports. The nursing home may share the services of a licensed administrator. The administrator must maintain ~~a sufficient~~ an on-site presence in the facility to effectively manage the facility in compliance with applicable rules and regulations. The administrator must establish procedures and delegate authority for on-site operations in the administrator's absence, but is ultimately responsible for the management of the facility. Each nursing home must have posted at all times the name of the administrator and the name of the person in charge on the premises in the absence of the licensed administrator.

~~(b) Notwithstanding sections 144A.18 to 144A.27, a nursing home with a director of nursing serving as an unlicensed nursing home administrator as of March 1, 2001, may continue to have a director of nursing serve in that capacity, provided the director of nursing has passed the state law and rules examination administered by the Board of Examiners for Nursing Home Administrators and maintains evidence of completion of 20 hours of continuing education each year on topics pertinent to nursing home administration.~~

Sec. 6. Minnesota Statutes 2018, section 144A.20, subdivision 1, is amended to read:

Subdivision 1. **Criteria.** The Board of ~~Examiners~~ Executives may issue licenses to qualified persons as nursing home administrators, and shall establish qualification criteria for nursing home administrators. No license shall be issued to a person as a nursing home administrator unless that person:

(1) is at least 21 years of age ~~and otherwise suitably qualified~~;

(2) has satisfactorily met standards set by the Board of ~~Examiners~~ Executives, which standards shall be designed to assure that nursing home administrators will be individuals who, by training or experience are qualified to serve as nursing home administrators; and

(3) has passed an examination approved by the board and designed to test for competence in the ~~subject matters~~ standards referred to in clause (2), or has been approved by the Board of ~~Examiners~~ Executives through the development and application of other appropriate techniques.

Sec. 7. Minnesota Statutes 2018, section 144A.24, is amended to read:

**144A.24 DUTIES OF THE BOARD.**

The Board of ~~Examiners~~ Executives shall:

(1) develop and enforce standards for nursing home administrator licensing, which standards shall be designed to assure that nursing home administrators will be individuals of good character who, by training or experience, are suitably qualified to serve as nursing home administrators;

(2) develop appropriate techniques, including examinations and investigations, for determining whether applicants and licensees meet the board's standards;

(3) issue licenses and permits to those individuals who are found to meet the board's standards;

(4) establish and implement procedures designed to assure that individuals licensed as nursing home administrators will comply with the board's standards;

(5) receive and investigate complaints and take appropriate action consistent with chapter 214, to revoke or suspend the license or permit of a nursing home administrator or acting administrator who fails to comply with sections 144A.18 to 144A.27 or the board's standards;

(6) conduct a continuing study and investigation of nursing homes, and the administrators of nursing homes within the state, with a view to the improvement of the standards imposed for the licensing of administrators and improvement of the procedures and methods used for enforcement of the board's standards; and

(7) approve or conduct courses of instruction or training designed to prepare individuals for licensing in accordance with the board's standards. ~~Courses designed to meet license renewal requirements shall be designed solely to improve professional skills and shall not~~

~~include classroom attendance requirements exceeding 50 hours per year.~~ The board may approve courses conducted within or without this state.

Sec. 8. Minnesota Statutes 2018, section 144A.26, is amended to read:

**144A.26 RECIPROCITY WITH OTHER STATES AND EQUIVALENCY OF HEALTH SERVICES EXECUTIVE.**

Subdivision 1. **Reciprocity.** The Board of ~~Examiners~~ Executives may issue a nursing home administrator's license, without examination, to any person who holds a current license as a nursing home administrator from another jurisdiction if the board finds that the standards for licensure in the other jurisdiction are at least the substantial equivalent of those prevailing in this state and that the applicant is otherwise qualified.

Subd. 2. **Health services executive license.** The Board of Executives may issue a health services executive license to any person who (1) has been validated by the National Association of Long Term Care Administrator Boards as a health services executive, and (2) has met the education and practice requirements for the minimum qualifications of a nursing home administrator, assisted living administrator, and home and community-based service provider. Licensure decisions made by the board under this subdivision are final.

Sec. 9. Minnesota Statutes 2018, section 144A.44, subdivision 1, is amended to read:

Subdivision 1. **Statement of rights.** (a) A ~~person~~ client who receives home care services in the community or in an assisted living facility licensed under chapter 144I has these rights:

(1) ~~the right to~~ receive written information, in plain language, about rights before receiving services, including what to do if rights are violated;

(2) ~~the right to~~ receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services;

(3) ~~the right to~~ be told before receiving services the type and disciplines of staff who will be providing the services, the frequency of visits proposed to be furnished, other choices that are available for addressing home care needs, and the potential consequences of refusing these services;

(4) ~~the right to~~ be told in advance of any recommended changes by the provider in the service plan and to take an active part in any decisions about changes to the service plan;

(5) ~~the right to~~ refuse services or treatment;

(6) ~~the right to~~ know, before receiving services or during the initial visit, any limits to the services available from a home care provider;

(7) ~~the right to~~ be told before services are initiated what the provider charges for the services; to what extent payment may be expected from health insurance, public programs, or other sources, if known; and what charges the client may be responsible for paying;

(8) ~~the right to~~ know that there may be other services available in the community, including other home care services and providers, and to know where to find information about these services;

(9) ~~the right to~~ choose freely among available providers and to change providers after services have begun, within the limits of health insurance, long-term care insurance, medical assistance, ~~or~~ other health programs, or public programs;

(10) ~~the right to~~ have personal, financial, and medical information kept private, and to be advised of the provider's policies and procedures regarding disclosure of such information;

(11) ~~the right to~~ access the client's own records and written information from those records in accordance with sections 144.291 to 144.298;

(12) ~~the right to~~ be served by people who are properly trained and competent to perform their duties;

(13) ~~the right to~~ be treated with courtesy and respect, and to have the client's property treated with respect;

(14) ~~the right to~~ be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act;

(15) ~~the right to~~ reasonable, advance notice of changes in services or charges;

(16) ~~the right to~~ know the provider's reason for termination of services;

(17) ~~the right to~~ at least ~~ten~~ 30 calendar days' advance notice of the termination of a service or housing by a provider, except in cases where:

(i) the client engages in conduct that significantly alters the terms of the service plan with the home care provider;

(ii) the client, person who lives with the client, or others create an abusive or unsafe work environment for the person providing home care services; or

(iii) an emergency or a significant change in the client's condition has resulted in service needs that exceed the current service plan and that cannot be safely met by the home care provider;

(18) ~~the right to~~ a coordinated transfer when there will be a change in the provider of services;

(19) ~~the right to~~ complain to staff and others of the client's choice about services that are provided, or fail to be provided, and the lack of courtesy or respect to the client or the client's property and the right to recommend changes in policies and services, free from retaliation including the threat of termination of services;

(20) ~~the right to~~ know how to contact an individual associated with the home care provider who is responsible for handling problems and to have the home care provider investigate and attempt to resolve the grievance or complaint;

(21) ~~the right to~~ know the name and address of the state or county agency to contact for additional information or assistance; ~~and~~

(22) ~~the right to~~ assert these rights personally, or have them asserted by the client's representative or by anyone on behalf of the client, without retaliation~~.~~; and

(23) place an electronic monitoring device in the client's or resident's space in compliance with state requirements.

(b) When providers violate the rights in this section, they are subject to the fines and license actions in sections 144A.474, subdivision 11, and 144A.475.

(c) Providers must do all of the following:

(1) encourage and assist in the fullest possible exercise of these rights;

(2) provide the names and telephone numbers of individuals and organizations that provide advocacy and legal services for clients and residents seeking to assert their rights;

(3) make every effort to assist clients or residents in obtaining information regarding whether Medicare, medical assistance, other health programs, or public programs will pay for services;

(4) make reasonable accommodations for people who have communication disabilities, or those who speak a language other than English; and

(5) provide all information and notices in plain language and in terms the client or resident can understand.

(d) No provider may require or request a client or resident to waive any of the rights listed in this section at any time or for any reasons, including as a condition of initiating services or entering into an assisted living facility contract.

Sec. 10. Minnesota Statutes 2018, section 144A.471, subdivision 7, is amended to read:

Subd. 7. **Comprehensive home care license provider.** Home care services that may be provided with a comprehensive home care license include any of the basic home care services listed in subdivision 6, and one or more of the following:

(1) services of an advanced practice nurse, registered nurse, licensed practical nurse, physical therapist, respiratory therapist, occupational therapist, speech-language pathologist, dietitian or nutritionist, or social worker;

(2) tasks delegated to unlicensed personnel by a registered nurse or assigned by a licensed health professional within the person's scope of practice;

(3) medication management services;

(4) hands-on assistance with transfers and mobility;

(5) treatment and therapies;

(6) assisting clients with eating when the clients have complicating eating problems as identified in the client record or through an assessment such as difficulty swallowing, recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous instruments to be fed; or

~~(6)~~ (7) providing other complex or specialty health care services.

Sec. 11. Minnesota Statutes 2018, section 144A.471, subdivision 9, is amended to read:

Subd. 9. **Exclusions from home care licensure.** The following are excluded from home care licensure and are not required to provide the home care bill of rights:

(1) an individual or business entity providing only coordination of home care that includes one or more of the following:

(i) determination of whether a client needs home care services, or assisting a client in determining what services are needed;

(ii) referral of clients to a home care provider;

(iii) administration of payments for home care services; or

(iv) administration of a health care home established under section 256B.0751;

(2) an individual who is not an employee of a licensed home care provider if the individual:

(i) only provides services as an independent contractor to one or more licensed home care providers;

(ii) provides no services under direct agreements or contracts with clients; and

(iii) is contractually bound to perform services in compliance with the contracting home care provider's policies and service plans;

(3) a business that provides staff to home care providers, such as a temporary employment agency, if the business:

(i) only provides staff under contract to licensed or exempt providers;

(ii) provides no services under direct agreements with clients; and

(iii) is contractually bound to perform services under the contracting home care provider's direction and supervision;

(4) any home care services conducted by and for the adherents of any recognized church or religious denomination for its members through spiritual means, or by prayer for healing;

(5) an individual who only provides home care services to a relative;

(6) an individual not connected with a home care provider that provides assistance with basic home care needs if the assistance is provided primarily as a contribution and not as a business;

(7) an individual not connected with a home care provider that shares housing with and provides primarily housekeeping or homemaking services to an elderly or disabled person in return for free or reduced-cost housing;

(8) an individual or provider providing home-delivered meal services;

(9) an individual providing senior companion services and other older American volunteer programs (OAVP) established under the Domestic Volunteer Service Act of 1973, United States Code, title 42, chapter 66;

~~(10) an employee of a nursing home or home care provider licensed under this chapter or an employee of a boarding care home licensed under sections 144.50 to 144.56 when responding to occasional emergency calls from individuals residing in a residential setting that is attached to or located on property contiguous to the nursing home, boarding care home, or location where home care services are also provided;~~

~~(11) an employee of a nursing home or home care provider licensed under this chapter or an employee of a boarding care home licensed under sections 144.50 to 144.56 when providing occasional minor services free of charge to individuals residing in a residential setting that is attached to or located on property contiguous to the nursing home, boarding care home, or location where home care services are also provided;~~

(12) a member of a professional corporation organized under chapter 319B that does not regularly offer or provide home care services as defined in section 144A.43, subdivision 3;

(13) the following organizations established to provide medical or surgical services that do not regularly offer or provide home care services as defined in section 144A.43, subdivision 3: a business trust organized under sections 318.01 to 318.04, a nonprofit corporation organized under chapter 317A, a partnership organized under chapter 323, or any other entity determined by the commissioner;

(14) an individual or agency that provides medical supplies or durable medical equipment, except when the provision of supplies or equipment is accompanied by a home care service;

(15) a physician licensed under chapter 147;

(16) an individual who provides home care services to a person with a developmental disability who lives in a place of residence with a family, foster family, or primary caregiver;

(17) a business that only provides services that are primarily instructional and not medical services or health-related support services;

(18) an individual who performs basic home care services for no more than 14 hours each calendar week to no more than one client;

(19) an individual or business licensed as hospice as defined in sections 144A.75 to 144A.755 who is not providing home care services independent of hospice service;

(20) activities conducted by the commissioner of health or a community health board as defined in section 145A.02, subdivision 5, including communicable disease investigations or testing; or

(21) administering or monitoring a prescribed therapy necessary to control or prevent a communicable disease, or the monitoring of an individual's compliance with a health directive as defined in section 144.4172, subdivision 6.

**EFFECTIVE DATE.** The amendments to clauses (10) and (11) are effective July 1, 2021.

Sec. 12. Minnesota Statutes 2018, section 144A.472, subdivision 7, is amended to read:

Subd. 7. **Fees; application, change of ownership, ~~and~~ renewal, and failure to notify.** (a) An initial applicant seeking temporary home care licensure must submit the following application fee to the commissioner along with a completed application:

(1) for a basic home care provider, $2,100; or

(2) for a comprehensive home care provider, $4,200.

(b) A home care provider who is filing a change of ownership as required under subdivision 5 must submit the following application fee to the commissioner, along with the documentation required for the change of ownership:

(1) for a basic home care provider, $2,100; or

(2) for a comprehensive home care provider, $4,200.

(c) For the period ending June 30, 2018, a home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted, according to the following schedule:

**License Renewal Fee**

| **Provider Annual Revenue** | **Fee** |
|---|---|
| greater than $1,500,000 | $6,625 |
| greater than $1,275,000 and no more than $1,500,000 | $5,797 |
| greater than $1,100,000 and no more than $1,275,000 | $4,969 |
| greater than $950,000 and no more than $1,100,000 | $4,141 |
| greater than $850,000 and no more than $950,000 | $3,727 |
| greater than $750,000 and no more than $850,000 | $3,313 |
| greater than $650,000 and no more than $750,000 | $2,898 |
| greater than $550,000 and no more than $650,000 | $2,485 |
| greater than $450,000 and no more than $550,000 | $2,070 |
| greater than $350,000 and no more than $450,000 | $1,656 |
| greater than $250,000 and no more than $350,000 | $1,242 |
| greater than $100,000 and no more than $250,000 | $828 |
| greater than $50,000 and no more than $100,000 | $500 |
| greater than $25,000 and no more than $50,000 | $400 |
| no more than $25,000 | $200 |

(d) For the period between July 1, 2018, and June 30, 2020, a home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner in an amount that is ten percent higher than the applicable fee in paragraph (c). A home care provider's fee shall be based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted.

(e) Beginning July 1, 2020, a home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted, according to the following schedule:

**License Renewal Fee**

| **Provider Annual Revenue** | **Fee** |
|---|---|
| greater than $1,500,000 | $7,651 |
| greater than $1,275,000 and no more than $1,500,000 | $6,695 |
| greater than $1,100,000 and no more than $1,275,000 | $5,739 |
| greater than $950,000 and no more than $1,100,000 | $4,783 |
| greater than $850,000 and no more than $950,000 | $4,304 |
| greater than $750,000 and no more than $850,000 | $3,826 |
| greater than $650,000 and no more than $750,000 | $3,347 |
| greater than $550,000 and no more than $650,000 | $2,870 |
| greater than $450,000 and no more than $550,000 | $2,391 |
| greater than $350,000 and no more than $450,000 | $1,913 |
| greater than $250,000 and no more than $350,000 | $1,434 |
| greater than $100,000 and no more than $250,000 | $957 |
| greater than $50,000 and no more than $100,000 | $577 |
| greater than $25,000 and no more than $50,000 | $462 |
| no more than $25,000 | $231 |

(f) If requested, the home care provider shall provide the commissioner information to verify the provider's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(g) At each annual renewal, a home care provider may elect to pay the highest renewal fee for its license category, and not provide annual revenue information to the commissioner.

(h) A temporary license or license applicant, or temporary licensee or licensee that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying

a lower license fee, shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

(i) The fee for failure to comply with the notification requirements in section 144A.473, subdivision 2, paragraph (c), is $1,000.

~~(i)~~ (j) Fees ~~and penalties~~ collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund. All fees are nonrefundable. Fees collected under paragraphs (c), (d), and (e) are nonrefundable even if received before July 1, 2017, for temporary licenses or licenses being issued effective July 1, 2017, or later.

(k) Fines collected under this subdivision shall be deposited in a dedicated special revenue account. On an annual basis, the balance in the special revenue account will be appropriated to the commissioner to implement the recommendations of the advisory council established in section 144A.4799. Fines collected in state fiscal years 2018 and 2019 shall be deposited in the dedicated special revenue account as described in this section.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 13. Minnesota Statutes 2018, section 144A.474, subdivision 9, is amended to read:

Subd. 9. **Follow-up surveys.** For providers that have Level 3 or Level 4 violations under subdivision 11, or any violations determined to be widespread, the department shall conduct a follow-up survey within 90 calendar days of the survey. When conducting a follow-up survey, the surveyor will focus on whether the previous violations have been corrected and may also address any new violations that are observed while evaluating the corrections that have been made. ~~If a new violation is identified on a follow-up survey, no fine will be imposed unless it is not corrected on the next follow-up survey.~~

Sec. 14. Minnesota Statutes 2018, section 144A.474, subdivision 11, is amended to read:

Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be assessed based on the level and scope of the violations described in paragraph ~~(c)~~ (b) and imposed immediately with no opportunity to correct the violation first as follows:

(1) Level 1, no fines or enforcement;

(2) Level 2, ~~fines ranging from $0 to~~ a fine of $500 per violation, in addition to any of the enforcement mechanisms authorized in section 144A.475 for widespread violations;

(3) Level 3, ~~fines ranging from $500 to $1,000~~ a fine of $3,000 per incident plus $100 for each resident affected by the violation, in addition to any of the enforcement mechanisms authorized in section 144A.475; ~~and~~

(4) Level 4, ~~fines ranging from $1,000 to~~ a fine of $5,000 per incident plus $200 for each resident affected by the violation, in addition to any of the enforcement mechanisms authorized in section 144A.475~~.~~;

(5) for maltreatment violations as defined in section 626.557 including abuse, neglect, financial exploitation, and drug diversion, that are determined against the provider, an immediate fine shall be imposed of $5,000 per incident plus $200 for each resident affected by the violation; and

(6) the fines in clauses (1) to (4) are increased and immediate fine imposition is authorized for both surveys and investigations conducted.

(b) Correction orders for violations are categorized by both level and scope and fines shall be assessed as follows:

(1) level of violation:

(i) Level 1 is a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety;

(ii) Level 2 is a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death;

(iii) Level 3 is a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death; and

(iv) Level 4 is a violation that results in serious injury, impairment, or death;

(2) scope of violation:

(i) isolated, when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally;

(ii) pattern, when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive; and

(iii) widespread, when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients.

(c) If the commissioner finds that the applicant or a home care provider ~~required to be licensed under sections 144A.43 to 144A.482~~ has not corrected violations by the date specified in the correction order or conditional license resulting from a survey or complaint investigation, the commissioner ~~may impose a fine. A~~ shall provide a notice of noncompliance with a correction order ~~must be mailed~~ by e-mail to the applicant's or provider's last known e-mail address. The noncompliance notice must list the violations not corrected.

(d) For every violation identified by the commissioner, the commissioner shall issue an immediate fine pursuant to paragraph (a), clause (6). The license holder must still correct the violation in the time specified. The issuance of an immediate fine can occur in addition to any enforcement mechanism authorized under section 144A.475. The immediate fine may be appealed as allowed under this subdivision.

~~(d)~~ (e) The license holder must pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies by paying the fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

~~(e)~~ (f) A license holder shall promptly notify the commissioner in writing when a violation specified in the order is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order, the commissioner may issue a second fine. The commissioner shall notify the license holder by mail to the last known address in the licensing record that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

~~(f)~~ (g) A home care provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14.

~~(g)~~ (h) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder shall be liable for payment of the fine.

~~(h)~~ (i) In addition to any fine imposed under this section, the commissioner may assess a penalty amount based on costs related to an investigation that results in a final order assessing a fine or other enforcement action authorized by this chapter.

~~(i)~~ (j) Fines collected under this subdivision shall be deposited in ~~the state government~~ a dedicated special revenue ~~fund and credited to an account separate from the revenue collected under section 144A.472. Subject to an appropriation by the legislature, the revenue~~

~~from the fines collected must be used by the commissioner for special projects to improve home care in Minnesota as recommended by~~ account. On an annual basis, the balance in the special revenue account shall be appropriated to the commissioner to implement the recommendations of the advisory council established in section 144A.4799. Fines collected in state fiscal years 2018 and 2019 shall be deposited in the dedicated special revenue account as described in this section.

Sec. 15. Minnesota Statutes 2018, section 144A.475, subdivision 3b, is amended to read:

Subd. 3b. **Expedited hearing.** (a) Within five business days of receipt of the license holder's timely appeal of a temporary suspension or issuance of a conditional license, the commissioner shall request assignment of an administrative law judge. The request must include a proposed date, time, and place of a hearing. A hearing must be conducted by an administrative law judge pursuant to Minnesota Rules, parts 1400.8505 to 1400.8612, within 30 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause. The commissioner shall issue a notice of hearing by certified mail or personal service at least ten business days before the hearing. Certified mail to the last known address is sufficient. The scope of the hearing shall be limited solely to the issue of whether the temporary suspension or issuance of a conditional license should remain in effect and whether there is sufficient evidence to conclude that the licensee's actions or failure to comply with applicable laws are level 3 or 4 violations as defined in section 144A.474, subdivision 11, paragraph (b), or that there were violations that posed an imminent risk of harm to the health and safety of persons in the provider's care.

(b) The administrative law judge shall issue findings of fact, conclusions, and a recommendation within ten business days from the date of hearing. The parties shall have ten calendar days to submit exceptions to the administrative law judge's report. The record shall close at the end of the ten-day period for submission of exceptions. The commissioner's final order shall be issued within ten business days from the close of the record. When an appeal of a temporary immediate suspension or conditional license is withdrawn or dismissed, the commissioner shall issue a final order affirming the temporary immediate suspension or conditional license within ten calendar days of the commissioner's receipt of the withdrawal or dismissal. The license holder is prohibited from operation during the temporary suspension period.

(c) When the final order under paragraph (b) affirms an immediate suspension, and a final licensing sanction is issued under subdivisions 1 and 2 and the licensee appeals that

sanction, the licensee is prohibited from operation pending a final commissioner's order after the contested case hearing conducted under chapter 14.

(d) A licensee whose license is temporarily suspended must comply with the requirements for notification and transfer of clients in subdivision 5. These requirements remain if an appeal is requested.

Sec. 16. Minnesota Statutes 2018, section 144A.475, subdivision 5, is amended to read:

Subd. 5. **Plan required.** (a) The process of suspending ~~or~~, revoking, or refusing to renew a license must include a plan for transferring affected ~~clients~~ clients' care to other providers by the home care provider, which will be monitored by the commissioner. Within three ~~business~~ calendar days of being notified of the ~~final~~ revocation, refusal to renew, or suspension ~~action~~, the home care provider shall provide the commissioner, the lead agencies as defined in section 256B.0911, county adult protection and case managers, and the ombudsman for long-term care with the following information:

(1) a list of all clients, including full names and all contact information on file;

(2) a list of each client's representative or emergency contact person, including full names and all contact information on file;

(3) the location or current residence of each client;

(4) the payor sources for each client, including payor source identification numbers; and

(5) for each client, a copy of the client's service plan, and a list of the types of services being provided.

(b) The revocation, refusal to renew, or suspension notification requirement is satisfied by mailing the notice to the address in the license record. The home care provider shall cooperate with the commissioner and the lead agencies, county adult protection and county managers, and the ombudsman for long term care during the process of transferring care of clients to qualified providers. Within three ~~business~~ calendar days of being notified of the final revocation, refusal to renew, or suspension action, the home care provider must notify and disclose to each of the home care provider's clients, or the client's representative or emergency contact persons, that the commissioner is taking action against the home care provider's license by providing a copy of the revocation, refusal to renew, or suspension notice issued by the commissioner. If the provider does not comply with the disclosure requirements in this section, the commissioner shall notify the clients, client representatives, or emergency contact persons about the action being taken. Lead agencies, county adult protection and county managers, and the Office of Ombudsman for Long-Term Care may

also provide this information. The revocation, refusal to renew, or suspension notice is public data except for any private data contained therein.

(c) A home care provider subject to this subdivision may continue operating during the period of time home care clients are being transferred to other providers.

Sec. 17. Minnesota Statutes 2018, section 144A.476, subdivision 1, is amended to read:

Subdivision 1. **Prior criminal convictions; owner and managerial officials.** (a) Before the commissioner issues a temporary license, issues a license as a result of an approved change in ownership, or renews a license, an owner or managerial official is required to complete a background study under section 144.057. No person may be involved in the management, operation, or control of a home care provider if the person has been disqualified under chapter 245C. If an individual is disqualified under section 144.057 or chapter 245C, the individual may request reconsideration of the disqualification. If the individual requests reconsideration and the commissioner sets aside or rescinds the disqualification, the individual is eligible to be involved in the management, operation, or control of the provider. If an individual has a disqualification under section 245C.15, subdivision 1, and the disqualification is affirmed, the individual's disqualification is barred from a set aside, and the individual must not be involved in the management, operation, or control of the provider.

(b) For purposes of this section, owners of a home care provider subject to the background check requirement are those individuals whose ownership interest provides sufficient authority or control to affect or change decisions related to the operation of the home care provider. An owner includes a sole proprietor, a general partner, or any other individual whose individual ownership interest can affect the management and direction of the policies of the home care provider.

(c) For the purposes of this section, managerial officials subject to the background check requirement are individuals who provide direct contact as defined in section 245C.02, subdivision 11, or individuals who have the responsibility for the ongoing management or direction of the policies, services, or employees of the home care provider. Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.

(d) The department shall not issue any license if the applicant or owner or managerial official has been unsuccessful in having a background study disqualification set aside under section 144.057 and chapter 245C; if the owner or managerial official, as an owner or managerial official of another home care provider, was substantially responsible for the other home care provider's failure to substantially comply with sections 144A.43 to

144A.482; or if an owner that has ceased doing business, either individually or as an owner of a home care provider, was issued a correction order for failing to assist clients in violation of this chapter.

Sec. 18. Minnesota Statutes 2018, section 144A.4791, subdivision 10, is amended to read:

Subd. 10. **Termination of service plan.** (a) If a home care provider terminates a service plan with a client, and the client continues to need home care services, the home care provider shall provide the client and the client's representative, if any, with a 30-day written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the reason for termination;

(3) a list of known licensed home care providers in the client's immediate geographic area;

(4) a statement that the home care provider will participate in a coordinated transfer of care of the client to another home care provider, health care provider, or caregiver, as required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);

(5) the name and contact information of a person employed by the home care provider with whom the client may discuss the notice of termination; and

(6) if applicable, a statement that the notice of termination of home care services does not constitute notice of termination of the housing with services contract with a housing with services establishment.

(b) When the home care provider voluntarily discontinues services to all clients, the home care provider must notify the commissioner, lead agencies, and ombudsman for long-term care about its clients and comply with the requirements in this subdivision.

Sec. 19. Minnesota Statutes 2018, section 144A.4799, is amended to read:

**144A.4799 DEPARTMENT OF HEALTH LICENSED HOME CARE PROVIDER ADVISORY COUNCIL.**

Subdivision 1. **Membership.** The commissioner of health shall appoint eight persons to a home care and assisted living program advisory council consisting of the following:

(1) three public members as defined in section 214.02 who shall be ~~either~~ persons who are currently receiving home care services ~~or~~, persons who have received home care services within five years of the application date, persons who have family members receiving home

care services, or persons who have family members who have received home care services within five years of the application date;

(2) three Minnesota home care licensees representing basic and comprehensive levels of licensure who may be a managerial official, an administrator, a supervising registered nurse, or an unlicensed personnel performing home care tasks;

(3) one member representing the Minnesota Board of Nursing; ~~and~~

(4) one member representing the office of ombudsman for long-term care~~.~~; and

(5) beginning July 1, 2021, one member of a county health and human services or county adult protection office.

Subd. 2. **Organizations and meetings.** The advisory council shall be organized and administered under section 15.059 with per diems and costs paid within the limits of available appropriations. Meetings will be held quarterly and hosted by the department. Subcommittees may be developed as necessary by the commissioner. Advisory council meetings are subject to the Open Meeting Law under chapter 13D.

Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide advice regarding regulations of Department of Health licensed home care providers in this chapter, including advice on the following:

(1) community standards for home care practices;

(2) enforcement of licensing standards and whether certain disciplinary actions are appropriate;

(3) ways of distributing information to licensees and consumers of home care;

(4) training standards;

(5) identifying emerging issues and opportunities in ~~the~~ home care ~~field, including~~;

(6) identifying the use of technology in home and telehealth capabilities;

~~(6)~~ (7) allowable home care licensing modifications and exemptions, including a method for an integrated license with an existing license for rural licensed nursing homes to provide limited home care services in an adjacent independent living apartment building owned by the licensed nursing home; and

~~(7)~~ (8) recommendations for studies using the data in section 62U.04, subdivision 4, including but not limited to studies concerning costs related to dementia and chronic disease

among an elderly population over 60 and additional long-term care costs, as described in section 62U.10, subdivision 6.

(b) The advisory council shall perform other duties as directed by the commissioner.

(c) The advisory council shall annually ~~review the balance of the account in the state government special revenue fund described in section 144A.474, subdivision 11, paragraph (i), and~~ make ~~annual~~ recommendations ~~by January 15 directly to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services regarding appropriations~~ to the commissioner for the purposes in section 144A.474, subdivision 11, paragraph (i). The recommendations shall address ways the commissioner may improve protection of the public under existing statutes and laws and include but are not limited to projects that create and administer training of licensees and their employees to improve residents lives, supporting ways that licensees can improve and enhance quality care, ways to provide technical assistance to licensees to improve compliance; information technology and data projects that analyze and communicate information about trends of violations or lead to ways of improving client care; communications strategies to licensees and the public; and other projects or pilots that benefit clients, families, and the public.

Sec. 20. Minnesota Statutes 2018, section 256I.03, subdivision 15, is amended to read:

Subd. 15. **Supportive housing.** "Supportive housing" means housing ~~with support services according to the continuum of care coordinated assessment system established under Code of Federal Regulations, title 24, section 578.3~~ that is not time-limited and provides or coordinates services necessary for a resident to maintain housing stability.

Sec. 21. Minnesota Statutes 2018, section 256I.04, subdivision 2a, is amended to read:

Subd. 2a. **License required; staffing qualifications.** (a) Except as provided in paragraph (b), an agency may not enter into an agreement with an establishment to provide housing support unless:

(1) the establishment is licensed by the Department of Health as a hotel and restaurant; a board and lodging establishment; a boarding care home before March 1, 1985; or a supervised living facility, and the service provider for residents of the facility is licensed under chapter 245A. However, an establishment licensed by the Department of Health to provide lodging need not also be licensed to provide board if meals are being supplied to residents under a contract with a food vendor who is licensed by the Department of Health;

(2) the residence is: (i) licensed by the commissioner of human services under Minnesota Rules, parts 9555.5050 to 9555.6265; (ii) certified by a county human services agency prior to July 1, 1992, using the standards under Minnesota Rules, parts 9555.5050 to 9555.6265; (iii) licensed by the commissioner under Minnesota Rules, parts 2960.0010 to 2960.0120, with a variance under section 245A.04, subdivision 9; or (iv) licensed under section 245D.02, subdivision 4a, as a community residential setting by the commissioner of human services; or

(3) the ~~establishment~~ facility is ~~registered~~ licensed under ~~chapter 144D~~ chapter 144I and provides three meals a day.

(b) The requirements under paragraph (a) do not apply to establishments exempt from state licensure because they are:

(1) located on Indian reservations and subject to tribal health and safety requirements; or

(2) ~~a supportive housing establishment that has an approved habitability inspection and an individual lease agreement and that serves people who have experienced long-term homelessness and were referred through a coordinated assessment in section 256I.03, subdivision 15~~ supportive housing establishments where an individual has an approved habitability inspection and an individual lease agreement.

(c) Supportive housing establishments that serve individuals who have experienced long-term homelessness and emergency shelters must participate in the homeless management information system and a coordinated assessment system as defined by the commissioner.

(d) Effective July 1, 2016, an agency shall not have an agreement with a provider of housing support unless all staff members who have direct contact with recipients:

(1) have skills and knowledge acquired through one or more of the following:

(i) a course of study in a health- or human services-related field leading to a bachelor of arts, bachelor of science, or associate's degree;

(ii) one year of experience with the target population served;

(iii) experience as a mental health certified peer specialist according to section 256B.0615; or

(iv) meeting the requirements for unlicensed personnel under sections 144A.43 to 144A.483;

(2) hold a current driver's license appropriate to the vehicle driven if transporting recipients;

(3) complete training on vulnerable adults mandated reporting and child maltreatment mandated reporting, where applicable; and

(4) complete housing support orientation training offered by the commissioner.

Sec. 22. Minnesota Statutes 2018, section 325F.72, subdivision 1, is amended to read:

Subdivision 1. **Persons to whom disclosure is required.** ~~Housing with services establishments, as defined in sections 144D.01 to 144D.07, that secure, segregate, or provide a special program or special unit for residents with a diagnosis of probable Alzheimer's disease or a related disorder or that advertise, market, or otherwise promote the establishment as providing specialized care for Alzheimer's disease or a related disorder are considered a "special care unit."~~ All ~~special care units~~ assisted living facilities with dementia care, as defined in section 144I.01, shall provide a written disclosure to the following:

(1) the commissioner of health, if requested;

(2) the Office of Ombudsman for Long-Term Care; and

(3) each person seeking placement within a residence, or the person's authorized representative, before an agreement to provide the care is entered into.

Sec. 23. Minnesota Statutes 2018, section 325F.72, subdivision 2, is amended to read:

Subd. 2. **Content.** Written disclosure shall include, but is not limited to, the following:

(1) a statement of the overall philosophy and how it reflects the special needs of residents with Alzheimer's disease or other dementias;

(2) the criteria for determining who may reside in the ~~special~~ dementia care unit;

(3) the process used for assessment and establishment of the service plan or agreement, including how the plan is responsive to changes in the resident's condition;

(4) staffing credentials, job descriptions, and staff duties and availability, including any training specific to dementia;

(5) physical environment as well as design and security features that specifically address the needs of residents with Alzheimer's disease or other dementias;

(6) frequency and type of programs and activities for residents ~~of the special care unit~~;

(7) involvement of families in resident care and availability of family support programs;

(8) fee schedules for additional services to the residents ~~of the special care unit~~; and

(9) a statement that residents will be given a written notice 30 calendar days prior to changes in the fee schedule.

Sec. 24. Minnesota Statutes 2018, section 626.5572, subdivision 6, is amended to read:

Subd. 6. **Facility.** (a) "Facility" means a hospital or other entity required to be licensed under sections 144.50 to 144.58; a nursing home required to be licensed to serve adults under section 144A.02; a facility or service required to be licensed under chapter 245A; an assisted living facility required to be licensed under chapter 144I; a home care provider licensed or required to be licensed under sections 144A.43 to 144A.482; a hospice provider licensed under sections 144A.75 to 144A.755; or a person or organization that offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under sections 256B.0625, subdivision 19a, 256B.0651 to 256B.0654, 256B.0659, or 256B.85.

(b) For services identified in paragraph (a) that are provided in the vulnerable adult's own home or in another unlicensed location, the term "facility" refers to the provider, person, or organization that offers, provides, or arranges for personal care services, and does not refer to the vulnerable adult's home or other location at which services are rendered.

Sec. 25. **REVISOR INSTRUCTION.**

The revisor of statutes shall change the phrases "Board of Examiners for Nursing Home Administrators" to "Board of Executives for Long Term Services and Supports" and "Board of Examiners" to "Board of Executives" wherever the phrases appear in Minnesota Statutes and apply to the board established in Minnesota Statutes, section 144A.19.

Sec. 26. **REPEALER.**

(a) Minnesota Statutes 2018, section 144A.472, subdivision 4, is repealed July 1, 2019.

(b) Minnesota Statutes 2018, sections 144A.441; and 144A.442, are repealed August 1, 2021.

# ARTICLE 19

# MISCELLANEOUS

Section 1. Minnesota Statutes 2018, section 124D.142, is amended to read:

**124D.142 QUALITY RATING AND IMPROVEMENT SYSTEM.**

(a) There is established a quality rating and improvement system (QRIS) framework to ensure that Minnesota's children have access to high-quality early learning and care programs in a range of settings so that they are fully ready for kindergarten ~~by 2020~~. ~~Creation of a~~ The standards-based voluntary quality rating and improvement system includes:

(1) quality opportunities in order to improve the educational outcomes of children so that they are ready for school. The framework shall be based on the Minnesota quality rating system rating tool and a common set of child outcome and program standards and informed by evaluation results;

(2) a tool to increase the number of publicly funded and regulated early learning and care services in both public and private market programs that are high quality. If a program or provider chooses to participate, the program or provider will be rated and may receive public funding associated with the rating. The state shall develop a plan to link future early learning and care state funding to the framework in a manner that complies with federal requirements; and

(3) tracking progress toward statewide access to high-quality early learning and care programs, progress toward the number of low-income children whose parents can access quality programs, and progress toward increasing the number of children who are fully prepared to enter kindergarten.

~~(b) In planning a statewide quality rating and improvement system framework in paragraph (a), the state shall use evaluation results of the Minnesota quality rating system rating tool in use in fiscal year 2008 to recommend:~~

~~(1) a framework of a common set of child outcome and program standards for a voluntary statewide quality rating and improvement system;~~

~~(2) a plan to link future funding to the framework described in paragraph (a), clause (2); and~~

~~(3) a plan for how the state will realign existing state and federal administrative resources to implement the voluntary quality rating and improvement system framework. The state shall provide the recommendation in this paragraph to the early childhood education finance committees of the legislature by March 15, 2011.~~

~~(c) Prior to the creation of a statewide quality rating and improvement system in paragraph (a), the state shall employ the Minnesota quality rating system rating tool in use in fiscal year 2008 in the original Minnesota Early Learning Foundation pilot areas and additional pilot areas supported by private or public funds with its modification as a result of the evaluation results of the pilot project.~~

(b) A child care provider who has a quality rating under this section and is disqualified from receiving child care assistance program reimbursement under chapter 119B, as provided under section 256.98, subdivision 8, paragraph (c), must also have the quality rating rescinded.

Sec. 2. Minnesota Statutes 2018, section 124D.165, subdivision 4, is amended to read:

Subd. 4. **Early childhood program eligibility.** (a) In order to be eligible ~~to accept an~~ for early learning scholarship funds, a program must:

(1) participate in the quality rating and improvement system under section 124D.142; and

(2) beginning July 1, 2020, have a three- or four-star rating in the quality rating and improvement system.

(b) Any program accepting scholarships must use the revenue to supplement and not supplant federal funding.

(c) Notwithstanding paragraph (a), all Minnesota early learning foundation scholarship program pilot sites are eligible to accept an early learning scholarship under this section.

(d) A program is not eligible for early learning scholarship funds if:

(1) it is disqualified from receiving payment for child care services from the child care assistance program under chapter 119B, as provided under section 256.98, subdivision 8, paragraph (c); or

(2) the commissioner of human services refuses to issue a child care authorization, revokes an existing child care authorization, stops payment issued to a program, or refuses to pay a bill under section 119B.13, subdivision 6, paragraph (d), clause (2).

**EFFECTIVE DATE.** This section is effective July 1, 2019.

Sec. 3. Minnesota Statutes 2018, section 125A.515, subdivision 1, is amended to read:

Subdivision 1. **Approval of on-site education programs.** The commissioner shall approve on-site education programs for placement of children and youth in residential

facilities including detention centers, before being licensed by the Department of Human Services or the Department of Corrections. Education programs in these facilities shall conform to state and federal education laws including the Individuals with Disabilities Education Act (IDEA). This section applies only to placements in children's residential facilities and psychiatric residential treatment facilities, as defined in section 256B.0625, subdivision 45a, licensed by the Department of Human Services or the Department of Corrections. For purposes of this section, "on-site education program" means the educational services provided directly on the grounds of the children's residential facility or psychiatric residential treatment facility to children and youth placed for care and treatment.

Sec. 4. Minnesota Statutes 2018, section 125A.515, subdivision 3, is amended to read:

Subd. 3. **Responsibilities for providing education.** (a) The district in which the children's residential facility or psychiatric residential treatment facility is located must provide education services, including special education if eligible, to all students placed in a facility.

(b) For education programs operated by the Department of Corrections, the providing district shall be the Department of Corrections. For students remanded to the commissioner of corrections, the providing and resident district shall be the Department of Corrections.

Sec. 5. Minnesota Statutes 2018, section 125A.515, subdivision 4, is amended to read:

Subd. 4. **Education services required.** (a) Education services must be provided to a student beginning within three business days after the student enters the children's residential facility or psychiatric residential treatment facility. The first four days of the student's placement may be used to screen the student for educational and safety issues.

(b) If the student does not meet the eligibility criteria for special education, regular education services must be provided to that student.

Sec. 6. Minnesota Statutes 2018, section 125A.515, subdivision 5, is amended to read:

Subd. 5. **Education programs for students placed in children's residential facilities.** (a) When a student is placed in a children's residential facility or psychiatric residential treatment facility under this section that has an on-site education program, the providing district, upon notice from the children's residential facility, must contact the resident district within one business day to determine if a student has been identified as having a disability, and to request at least the student's transcript, and for students with disabilities, the most recent individualized education program (IEP) and evaluation report.

The resident district must send a facsimile copy to the providing district within two business days of receiving the request.

(b) If a student placed under this section has been identified as having a disability and has an individualized education program in the resident district:

(1) the providing agency must conduct an individualized education program meeting to reach an agreement about continuing or modifying special education services in accordance with the current individualized education program goals and objectives and to determine if additional evaluations are necessary; and

(2) at least the following people shall receive written notice or documented phone call to be followed with written notice to attend the individualized education program meeting:

(i) the person or agency placing the student;

(ii) the resident district;

(iii) the appropriate teachers and related services staff from the providing district;

(iv) appropriate staff from the children's residential facility or psychiatric residential treatment facility;

(v) the parents or legal guardians of the student; and

(vi) when appropriate, the student.

(c) For a student who has not been identified as a student with a disability, a screening must be conducted by the providing districts as soon as possible to determine the student's educational and behavioral needs and must include a review of the student's educational records.

Sec. 7. Minnesota Statutes 2018, section 125A.515, subdivision 7, is amended to read:

Subd. 7. **Minimum educational services required.** When a student is placed in a children's residential facility or psychiatric residential treatment facility under this section, at a minimum, the providing district is responsible for:

(1) the education necessary, including summer school services, for a student who is not performing at grade level as indicated in the education record or IEP; and

(2) a school day, of the same length as the school day of the providing district, unless the unique needs of the student, as documented through the IEP or education record in consultation with treatment providers, requires an alteration in the length of the school day.

Sec. 8. Minnesota Statutes 2018, section 125A.515, subdivision 8, is amended to read:

Subd. 8. **Placement, services, and due process.** When a student's treatment and educational needs allow, education shall be provided in a regular educational setting. The determination of the amount and site of integrated services must be a joint decision between the student's parents or legal guardians and the treatment and education staff. When applicable, educational placement decisions must be made by the IEP team of the providing district. Educational services shall be provided in conformance with the least restrictive environment principle of the Individuals with Disabilities Education Act. The providing district and children's residential facility or psychiatric residential treatment facility shall cooperatively develop discipline and behavior management procedures to be used in emergency situations that comply with the Minnesota Pupil Fair Dismissal Act and other relevant state and federal laws and regulations.

Sec. 9. **[137.68] ADVISORY COUNCIL ON RARE DISEASES.**

Subdivision 1. **Establishment.** The University of Minnesota is requested to establish an advisory council on rare diseases to provide advice on research, diagnosis, treatment, and education related to rare diseases. For purposes of this section, "rare disease" has the meaning given in United States Code, title 21, section 360bb. The council shall be called the Chloe Barnes Advisory Council on Rare Diseases.

Subd. 2. **Membership.** (a) The advisory council may consist of public members appointed by the Board of Regents or a designee according to paragraph (b) and four members of the legislature appointed according to paragraph (c).

(b) The Board of Regents or a designee is requested to appoint the following public members:

(1) three physicians licensed and practicing in the state with experience researching, diagnosing, or treating rare diseases. At least one physician appointed under this clause must be a pediatrician;

(2) one registered nurse or advanced practice registered nurse licensed and practicing in the state with experience treating rare diseases;

(3) at least two hospital administrators, or their designees, from hospitals in the state that provide care to persons diagnosed with a rare disease. One administrator or designee appointed under this clause must represent a hospital in which the scope of service focuses on rare diseases of pediatric patients;

(4) three persons age 18 or older who either have a rare disease or are a caregiver of a person with a rare disease;

(5) a representative of a rare disease patient organization that operates in the state;

(6) a social worker with experience providing services to persons diagnosed with a rare disease;

(7) a pharmacist with experience with drugs used to treat rare diseases;

(8) a dentist licensed and practicing in the state with experience treating rare diseases;

(9) a representative of the biotechnology industry;

(10) a representative of health plan companies;

(11) a medical researcher with experience conducting research on rare diseases; and

(12) a genetic counselor with experience providing services to persons diagnosed with a rare disease or caregivers of those persons.

(c) The advisory council shall include two members of the senate, one appointed by the majority leader and one appointed by the minority leader; and two members of the house of representatives, one appointed by the speaker of the house and one appointed by the minority leader.

(d) The commissioner of health or a designee, a representative of Mayo Medical School, and a representative of the University of Minnesota Medical School, shall serve as ex officio, nonvoting members of the advisory council.

(e) Initial appointments to the advisory council shall be made no later than September 1, 2019. Members appointed according to paragraph (b) shall serve for a term of three years, except that the initial members appointed according to paragraph (b) shall have an initial term of two, three, or four years determined by lot by the chairperson. Members appointed according to paragraph (b) shall serve until their successors have been appointed.

Subd. 3. **Meetings.** The Board of Regents or a designee is requested to convene the first meeting of the advisory council no later than October 1, 2019. The advisory council shall meet at the call of the chairperson or at the request of a majority of advisory council members.

Subd. 4. **Duties.** (a) The advisory council's duties may include, but are not limited to:

(1) in conjunction with the state's medical schools, the state's schools of public health, and hospitals in the state that provide care to persons diagnosed with a rare disease,

developing resources or recommendations relating to quality of and access to treatment and services in the state for persons with a rare disease, including but not limited to:

(i) a list of existing, publicly accessible resources on research, diagnosis, treatment, and education relating to rare diseases;

(ii) identifying best practices for rare disease care implemented in other states, at the national level, and at the international level, that will improve rare disease care in the state and seeking opportunities to partner with similar organizations in other states and countries;

(iii) identifying problems faced by patients with a rare disease when changing health plans, including recommendations on how to remove obstacles faced by these patients to finding a new health plan and how to improve the ease and speed of finding a new health plan that meets the needs of patients with a rare disease; and

(iv) identifying best practices to ensure health care providers are adequately informed of the most effective strategies for recognizing and treating rare diseases; and

(2) advising, consulting, and cooperating with the Department of Health, the Advisory Committee on Heritable and Congenital Disorders, and other agencies of state government in developing information and programs for the public and the health care community relating to diagnosis, treatment, and awareness of rare diseases.

(b) The advisory council shall collect additional topic areas for study and evaluation from the general public. In order for the advisory council to study and evaluate a topic, the topic must be approved for study and evaluation by the advisory council.

Subd. 5. **Conflict of interest.** Advisory council members are subject to the Board of Regents policy on conflicts of interest.

Subd. 6. **Annual report.** By January 1 of each year, beginning January 1, 2020, the advisory council shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over higher education and health care policy on the advisory council's activities under subdivision 4 and other issues on which the advisory council may choose to report.

Sec. 10. Minnesota Statutes 2018, section 256I.05, subdivision 1c, is amended to read:

Subd. 1c. **Rate increases.** An agency may not increase the rates negotiated for housing support above those in effect on June 30, 1993, except as provided in paragraphs (a) to (f).

(a) An agency may increase the rates for room and board to the MSA equivalent rate for those settings whose current rate is below the MSA equivalent rate.

(b) An agency may increase the rates for residents in adult foster care whose difficulty of care has increased. The total housing support rate for these residents must not exceed the maximum rate specified in subdivisions 1 and 1a. Agencies must not include nor increase difficulty of care rates for adults in foster care whose difficulty of care is eligible for funding by home and community-based waiver programs under title XIX of the Social Security Act.

(c) The room and board rates will be increased each year when the MSA equivalent rate is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase, less the amount of the increase in the medical assistance personal needs allowance under section 256B.35.

(d) When housing support pays for an individual's room and board, or other costs necessary to provide room and board, the rate payable to the residence must continue for up to 18 calendar days per incident that the person is temporarily absent from the residence, not to exceed 60 days in a calendar year, if the absence or absences have received the prior approval of the county agency's social service staff. Prior approval is not required for emergency absences due to crisis, illness, or injury.

(e) For facilities meeting substantial change criteria within the prior year. Substantial change criteria exists if the establishment experiences a 25 percent increase or decrease in the total number of its beds, if the net cost of capital additions or improvements is in excess of 15 percent of the current market value of the residence, or if the residence physically moves, or changes its licensure, and incurs a resulting increase in operation and property costs.

(f) Until June 30, 1994, an agency may increase by up to five percent the total rate paid for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who reside in residences that are licensed by the commissioner of health as a boarding care home, but are not certified for the purposes of the medical assistance program. However, an increase under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical assistance reimbursement rate for nursing home resident class A, in the geographic grouping in which the facility is located, as established under Minnesota Rules, parts 9549.0051 to 9549.0058.

(g) An agency may increase the rates by $100 per month for residents in settings under sections 144D.025 and 256I.04, subdivision 2a, paragraph (b), clause (2).

## ARTICLE 20

## HUMAN SERVICES FORECAST ADJUSTMENTS

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2017, First Special Session chapter 6, article 18, from the general fund, or any other fund named, to the commissioner of human services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figure "2019" used in this article means that the appropriations listed are available for the fiscal year ending June 30, 2019.

| | **APPROPRIATIONS Available for the Year Ending June 30 2019** |
|---|---|
| Sec. 2. **COMMISSIONER OF HUMAN SERVICES** | |
| Subdivision 1. **Total Appropriation** | **$ (318,423,000)** |
| Appropriations by Fund | |
| 2019 | |
| General (317,538,000) | |
| Health Care Access 8,410,000 | |
| Federal TANF (9,295,000) | |
| Subd. 2. **Forecasted Programs** | |
| (a) **Minnesota Family Investment Program (MFIP)/Diversionary Work Program (DWP)** | |
| Appropriations by Fund | |
| General (19,361,000) | |
| Federal TANF (8,893,000) | |
| (b) **MFIP Child Care Assistance** | (16,789,000) |
| (c) **General Assistance** | (7,928,000) |
| (d) **Minnesota Supplemental Aid** | (549,000) |
| (e) **Housing Support** | (13,836,000) |
| (f) **Northstar Care for Children** | (19,027,000) |
| (g) **MinnesotaCare** | 8,410,000 |
| This appropriation is from the health care access fund. | |

(h) **Medical Assistance**

Appropriations by Fund

General (222,176,000)

Health Care Access -0-

(i) **Alternative Care** -0-

(j) **Consolidated Chemical Dependency Treatment Fund (CCDTF) Entitlement** (17,872,000)

Subd. 3. **Technical Activities** (402,000)

This appropriation is from the federal TANF fund.

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment.

## ARTICLE 21

## APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2020" and "2021" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2020, or June 30, 2021, respectively. "The first year" is fiscal year 2020. "The second year" is fiscal year 2021. "The biennium" is fiscal years 2020 and 2021.

| | **APPROPRIATIONS** | |
|---|---|---|
| | **Available for the Year** | |
| | **Ending June 30** | |
| | **2020** | **2021** |

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation** **$ 8,244,381,000 $ 8,390,392,000**

| | Appropriations by Fund | |
|---|---|---|
| | 2020 | 2021 |
| General | 7,408,609,000 | 7,544,806,000 |
| State Government Special Revenue | 16,193,000 | 16,148,000 |
| Health Care Access | 531,064,000 | 555,550,000 |
| Federal TANF | 273,620,000 | 271,992,000 |
| Lottery Prize | 1,896,000 | 1,896,000 |

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **TANF Maintenance of Effort**

(a) **Nonfederal Expenditures.** The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1. In order to meet these basic TANF/MOE requirements, the commissioner may report as TANF/MOE expenditures only nonfederal money expended for allowable activities listed in the following clauses:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671;

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674; and

(8) qualifying Head Start expenditures under Minnesota Statutes, section 119A.50.

(b) **Nonfederal Expenditures; Reporting.** For the activities listed in paragraph (a), clauses (2) to (8), the commissioner may report only expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) **Certain Expenditures Required.** The commissioner shall ensure that the MOE used by the commissioner of management and budget for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(d) **Limitation; Exceptions.** The commissioner must not claim an amount of TANF/MOE in excess of the 75 percent

standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43 (a)(2).

(e) **Supplemental Expenditures.** For the purposes of paragraph (d), the commissioner may supplement the MOE claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision.

(f) **Reduction of Appropriations; Exception.** The requirement in Minnesota Statutes, section 256.011, subdivision 3, that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, does not apply if the grants or aids are federal TANF funds.

(g) **IT Appropriations Generally.** This appropriation includes funds for information technology projects, services, and support. Notwithstanding Minnesota Statutes, section 16E.0466, funding for information technology project costs shall be incorporated into the service level agreement and paid to the Office of MN.IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(h) **Receipts for Systems Project.** Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, ISDS, METS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the commissioner of the Office of MN.IT Services, funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

(i) **Federal SNAP Education and Training Grants.** Federal funds available during fiscal years 2020 and 2021 for Supplemental Nutrition Assistance Program Education and Training and SNAP Quality Control Performance Bonus grants are appropriated to the commissioner of human services for the

purposes allowable under the terms of the federal award. This paragraph is effective the day following final enactment.

Subd. 3. **Working Family Credit as TANF/MOE**

The commissioner may claim as TANF/MOE up to $6,707,000 per year of working family credit expenditures in each fiscal year.

Subd. 4. **Central Office; Operations**

| | Appropriations by Fund | |
|---|---|---|
| General | 152,118,000 | 149,405,000 |
| State Government Special Revenue | 5,451,000 | 5,441,000 |
| Health Care Access | 21,620,000 | 22,656,000 |
| Federal TANF | 100,000 | 100,000 |

(a) **Administrative Recovery; Set-Aside.** The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

(1) Minnesota Statutes, section 125A.744, subdivision 3;

(2) Minnesota Statutes, section 245.495, paragraph (b);

(3) Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

(b) **Minnesota Pathways to Prosperity and Well-Being Pilot Project.** $1,000,000 in fiscal

year 2020 and $1,000,000 in fiscal year 2021 are from the general fund for grants to Dakota and Olmsted Counties to implement the Minnesota Pathways to Prosperity and Well-Being pilot project described in Laws 2017, First Special Session chapter 6, article 7, section 34. The commissioner shall release the grant funds only upon verifying that sufficient funds have been raised to fully fund a unified benefit set for the 100 clients in the pilot project. The commissioner shall provide authorization to Dakota and Olmsted Counties to operate the pilot project. The base for this appropriation is $1,000,000 in fiscal year 2022 and $0 in fiscal year 2023. These appropriations are available until June 30, 2022.

(c) **Child Care Licensing Inspections.** $673,000 in fiscal year 2020 and $722,000 in fiscal year 2021 are from the general fund to add eight child care licensing staff for the purpose of increasing the frequency of inspections of child care centers to ensure the health and safety of children in care, provide technical assistance to newly licensed programs, and monitor struggling programs more closely to evaluate whether the program should be referred to the Office of Inspector General for a potential fraud investigation.

(d) **Child Care Assistance Programs - Fraud and Abuse Data Analysts.** $317,000 in fiscal year 2020 and $339,000 in fiscal year 2021 are from the general fund to add two data analysts to strengthen the commissioner's ability to identify, detect, and prevent fraud

and abuse in the child care assistance programs under Minnesota Statutes, chapter 119B.

(e) **Office of Inspector General Investigators.** $418,000 in fiscal year 2020 and $483,000 in fiscal year 2021 are from the general fund to add four investigators to the Office of Inspector General to detect, prevent, and make recoveries from fraudulent activities among providers in the medical assistance program under Minnesota Statutes, chapter 256B.

(f) **Office of Inspector General Tracking System.** $355,000 in fiscal year 2020 and $105,000 in fiscal year 2021 are from the general fund to purchase a system to record, track, and report on investigative activity for the Office of Inspector General to strengthen fraud prevention and investigation activities for child care assistance programs under Minnesota Statutes, chapter 119B.

(g) **Fraud Prevention Investigation Grant Program.** $529,000 in fiscal year 2020 and $546,000 in fiscal year 2021 are from the general fund for the fraud prevention investigation grant program under Minnesota Statutes, section 256.983. Of these amounts, the commissioner may use up to $104,000 in fiscal year 2020 and up to $121,000 in fiscal year 2021 to add one permanent full-time equivalent employee to support the grant program.

(h) **Child Care Assistance Programs - Law Enforcement.** $350,000 in fiscal year 2020 and $350,000 in fiscal year 2021 are from the general fund to add two additional law

enforcement officers under contract with the Bureau of Criminal Apprehension to conduct criminal investigations in child care assistance program cases.

(i) **Base Level Adjustment.** The general fund base is $147,040,000 in fiscal year 2022 and $148,502,000 in fiscal year 2023. The health care access fund base is $22,644,000 in fiscal year 2022 and $20,894,000 in fiscal year 2023. The state government special revenue fund base is $5,441,000 in fiscal year 2022 and $5,442,000 in fiscal year 2023.

Subd. 5. **Central Office; Children and Families**

| | Appropriations by Fund | |
|---|---|---|
| General | 13,598,000 | 14,424,000 |
| Federal TANF | 2,582,000 | 2,582,000 |

(a) **Financial Institution Data Match and Payment of Fees.** The commissioner is authorized to allocate up to $310,000 each year in fiscal year 2020 and fiscal year 2021 from the systems special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

(b) **Child Welfare Training Academy.** $1,371,000 in fiscal year 2020 and $2,517,000 in fiscal year 2021 are from the general fund for the Child Welfare Training Academy for the provision of child protection worker training under Minnesota Statutes, section 626.5591, subdivision 2.

(c) **Child Care Assistance Programs - Improvements.** $71,000 in fiscal year 2020 and $82,000 in fiscal year 2021 are from the general fund to add one temporary staff person to plan for improvements to provider registration and oversight for the child care assistance programs under Minnesota Statutes, chapter 119B. This is a onetime appropriation.

(d) **Base Level Adjustment.** The general fund base is $14,540,000 in fiscal year 2022 and $14,793,000 in fiscal year 2023.

Subd. 6. **Central Office; Health Care**

| | Appropriations by Fund | |
|---|---|---|
| General | 23,337,000 | 24,397,000 |
| State Government Special Revenue | 277,000 | 242,000 |
| Health Care Access | 25,456,000 | 25,344,000 |

(a) **Nonemergency Medical Transportation Program Audits.** $557,000 in fiscal year 2020 and $1,119,000 in fiscal year 2021 are from the general fund to conduct audits of the nonemergency medical transportation program.

(b) **Outpatient Pharmacy.** $113,000 in fiscal year 2020 and $50,000 in fiscal year 2021 are from the general fund to contract for 340B pharmacy data in order to perform the new pricing calculations and conduct a cost of dispensing survey.

(c) **Advisory Council on Rare Diseases.** $150,000 in fiscal year 2020 and $150,000 in fiscal year 2021 are from the general fund for transfer to the Board of Regents of the University of Minnesota for the advisory

council on rare diseases under Minnesota Statutes, section 137.68.

(d) **Base Level Adjustment.** The general fund base is $27,441,000 in fiscal year 2022 and $29,757,000 in fiscal year 2023. The state government special revenue fund base is $242,000 in fiscal year 2022 and $242,000 in fiscal year 2023. The health care access fund base is $26,449,000 in fiscal year 2022 and $27,197,000 in fiscal year 2023.

Subd. 7. **Central Office; Continuing Care for Older Adults**

| | Appropriations by Fund | |
|---|---|---|
| General | 20,460,000 | 18,096,000 |
| State Government Special Revenue | 125,000 | 125,000 |

(a) **Assisted Living Survey.** Beginning in fiscal year 2020, $2,500,000 is appropriated in the even numbered year of each biennium to fund a resident experience survey and family survey for all housing with services sites. This paragraph does not expire.

(b) **Information and Assistance Grant Transfer.** $1,000,000 in fiscal year 2020 and $1,000,000 in fiscal year 2021 are transferred to the continuing care for older adults administration from the aging and adult services grants for developing the Home and Community-Based Report Card for assisted living. This transfer is ongoing.

(c) **Base Level Adjustment.** The general fund base is $20,591,000 in fiscal year 2022 and $18,111,000 in fiscal year 2023. The state government special revenue fund base is

$125,000 in fiscal year 2022 and $125,000 in fiscal year 2023.

Subd. 8. **Central Office; Community Supports**

| | Appropriations by Fund | |
|---|---|---|
| General | 37,346,000 | 37,238,000 |
| Lottery Prize | 163,000 | 163,000 |

(a) **Certified Community Behavioral Health Center (CCBHC) Expansion.** $310,000 in fiscal year 2020 and $285,000 in fiscal year 2021 are from the general fund to support CCBHC expansion.

(b) **Homeless Management Information System.** $1,000,000 in fiscal year 2020 and $1,000,000 in fiscal year 2021 are from the general fund for support of the Homeless Management Information System (HMIS).

(c) **Base Level Adjustment.** The general fund base is $36,783,000 in fiscal year 2022 and $36,483,000 in fiscal year 2023.

Subd. 9. **Forecasted Programs; MFIP/DWP**

| | Appropriations by Fund | |
|---|---|---|
| General | 89,448,000 | 111,069,000 |
| Federal TANF | 78,705,000 | 76,851,000 |

**Child Care Assistance for Certain Caregivers.** $200,000 in fiscal year 2020 and $200,000 in fiscal year 2021 are from the general fund for child care assistance under Minnesota Statutes, section 119B.05, subdivision 1, clause (11).

| | | |
|---|---|---|
| Subd. 10. **Forecasted Programs; MFIP Child Care Assistance** | 107,238,000 | 124,504,000 |
| Subd. 11. **Forecasted Programs; General Assistance** | 49,959,000 | 50,586,000 |

(a) **General Assistance Standard.** The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

(b) **Emergency General Assistance Limit.** The amount appropriated for emergency general assistance is limited to no more than $6,729,812 in fiscal year 2020 and $6,729,812 in fiscal year 2021. Funds to counties shall be allocated by the commissioner using the allocation method under Minnesota Statutes, section 256D.06.

| | | |
|---|---|---|
| Subd. 12. **Forecasted Programs; Minnesota Supplemental Aid** | 42,348,000 | 46,420,000 |
| Subd. 13. **Forecasted Programs; Housing Support** | 167,645,000 | 170,218,000 |
| Subd. 14. **Forecasted Programs; Northstar Care for Children** | 86,497,000 | 94,095,000 |
| Subd. 15. **Forecasted Programs; MinnesotaCare** | 25,100,000 | 31,274,000 |

(a) **Generally.** This appropriation is from the health care access fund.

(b) **OneCare Buy-In Option.** The fiscal year 2023 base for MinnesotaCare is increased by $112,000,000 to serve as a reserve for the Department of Human Services to operationalize the OneCare Buy-In Option under Minnesota Statutes, chapter 256T. This is a onetime increase.

Subd. 16. **Forecasted Programs; Medical Assistance**

Appropriations by Fund

| | | |
|---|---|---|
| General | 5,654,457,000 | 5,714,974,000 |
| Health Care Access | 454,673,000 | 472,061,000 |

(a) **Behavioral Health Services.** $1,000,000 in fiscal year 2020 and $1,000,000 in fiscal year 2021 are for behavioral health services provided by hospitals identified under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (a), clause (4). The increase in payments shall be made by increasing the adjustment under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (e), clause (2).

(b) **Base Level Adjustment.** The health care access fund base is $492,550,000 in fiscal year 2022 and $499,310,000 in fiscal year 2023.

Subd. 17. **Forecasted Programs; Alternative Care** 45,243,000 45,245,000

**Alternative Care Transfer.** Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

Subd. 18. **Forecasted Programs; Chemical Dependency Treatment Fund** 131,372,000 135,609,000

Subd. 19. **Grant Programs; Support Services Grants**

Appropriations by Fund

| | | |
|---|---|---|
| General | 8,715,000 | 8,715,000 |
| Federal TANF | 96,312,000 | 96,311,000 |

Subd. 20. **Grant Programs; Basic Sliding Fee Child Care Assistance Grants** 63,935,000 75,046,000

(a) **Basic Sliding Fee Waiting List Allocation.** Notwithstanding Minnesota Statutes, section 119B.03, $7,821,000 in fiscal

year 2020 and $17,901,000 in fiscal year 2021 are to reduce the basic sliding fee program waiting list as follows:

(1) the calendar year 2020 allocation shall be increased to serve families on the waiting list. To receive funds appropriated for this purpose, a county must have a waiting list in the most recent published waiting list month;

(2) funds shall be distributed proportionately based on the average of the most recent six months of published waiting lists to counties that meet the criteria in clause (1);

(3) allocations in calendar years 2021 and beyond shall be calculated using the allocation formula in Minnesota Statutes, section 119B.03; and

(4) the guaranteed floor for calendar year 2021 shall be based on the revised calendar year 2020 allocation.

(b) **Increase for Maximum Rates.** Notwithstanding Minnesota Statutes, section 119B.03, subdivisions 6, 6a, and 6b, the commissioner must allocate the additional basic sliding fee child care funds for calendar year 2020 to counties for updated maximum rates based on relative need to cover maximum rate increases. In distributing the additional funds, the commissioner shall consider the following factors by county:

(1) number of children;

(2) provider type;

(3) age of children; and

(4) amount of the increase in maximum rates.

(c) **Base Level Adjustment.** The general fund base is $79,556,000 in fiscal year 2022 and $86,527,000 in fiscal year 2023.

Subd. 21. **Grant Programs; Child Care Development Grants** 2,337,000 2,337,000

(a) **First Children's Finance Child Care Site Assistance Grant.** $500,000 in fiscal year 2020 and $500,000 in fiscal year 2021 are for a grant to First Children's Finance for loans to improve or increase availability of child care or early childhood education sites. This is a onetime appropriation.

(b) **REETAIN Grant.** $100,000 in fiscal year 2020 and $100,000 in fiscal year 2021 are for the REETAIN grant program under Minnesota Statutes, section 119B.195. The unencumbered balance in the first year does not cancel but is available for the second year.

(c) **Base Level Adjustment.** The general fund base is $1,837,000 in fiscal year 2022 and $1,837,000 in fiscal year 2023.

Subd. 22. **Grant Programs; Child Support Enforcement Grants** 50,000 50,000

Subd. 23. **Grant Programs; Children's Services Grants**

| | Appropriations by Fund | |
|---|---|---|
| General | 44,282,000 | 48,785,000 |
| Federal TANF | 140,000 | 140,000 |

(a) **Title IV-E Adoption Assistance.** (1) The commissioner shall allocate funds from the Title IV-E reimbursement to the state from the Fostering Connections to Success and Increasing Adoptions Act for adoptive, foster, and kinship families as required in Minnesota Statutes, section 256N.261.

(2) Additional federal reimbursement to the state as a result of the Fostering Connections to Success and Increasing Adoptions Act's expanded eligibility for title IV-E adoption assistance is for postadoption, foster care, adoption, and kinship services, including a parent-to-parent support network.

(b) **Parent Support for Better Outcomes Grants.** $150,000 in fiscal year 2020 and $150,000 in fiscal year 2021 are from the general fund for grants to Minnesota One-Stop for Communities to provide mentoring, guidance, and support services to parents navigating the child welfare system in Minnesota in order to promote the development of safe, stable, and healthy families. Grant funds may be used for parent mentoring, peer-to-peer support groups, housing support services, training, staffing, and administrative costs. This is a onetime appropriation.

(c) **Sexually Exploited Youth and Youth At Risk of Sexual Exploitation.** $250,000 in fiscal year 2020 and $250,000 in fiscal year 2021 are from the general fund for activities under the safe harbor program. This is a onetime appropriation.

(d) **Family Foster Care Improvement Models.** $75,000 in fiscal year 2020 is from the general fund for a grant to Hennepin County to establish and promote family foster care recruitment models. The county shall use the grant funds to increase foster care providers through administrative simplification, nontraditional recruitment

models, and family incentive options, and develop a strategic planning model to recruit family foster care providers. This is a onetime appropriation.

(e) **Base Level Adjustment.** The general fund base is $51,483,000 in fiscal year 2022 and $51,198,000 in fiscal year 2023.

Subd. 24. **Grant Programs; Children and Community Service Grants** 59,201,000 59,701,000

(a) **Adult Protection Grants.** $1,000,000 in fiscal year 2020 and $1,500,000 in fiscal year 2021 are for grant funding for adult abuse maltreatment investigations and adult protective services to counties and tribes as allocated and specified under Minnesota Statutes, section 256M.42.

(b) **Base Level Adjustment.** The general fund base is $60,251,000 in fiscal year 2022 and $60,856,000 in fiscal year 2023.

Subd. 25. **Grant Programs; Children and Economic Support Grants** 23,175,000 22,915,000

(a) **Minnesota Food Assistance Program.** Unexpended funds for the Minnesota food assistance program for fiscal year 2020 do not cancel but are available for this purpose in fiscal year 2021.

(b) **Replicable Homeless Youth Drop-In Program Model.** $100,000 in fiscal year 2020 and $100,000 in fiscal year 2021 are for a grant to an organization in Anoka County providing services and programming through a drop-in program to meet the basic needs, including mental health needs, of homeless youth in the northern metropolitan suburbs, to develop a model of its homeless youth

drop-in program that can be shared and replicated in other communities throughout Minnesota. This is a onetime appropriation.

(c) **Community Action Grants.** $500,000 in fiscal year 2020 and $500,000 in fiscal year 2021 are for community action grants under Minnesota Statutes, sections 256E.30 to 256E.32. This is a onetime appropriation.

(d) **Food Shelf Programs.** $260,000 in fiscal year 2020 is for food shelf programs under Minnesota Statutes, section 256E.34, to purchase diapers. Hunger Solutions must establish an application process for food shelves and determine the allocation of money to food shelves. This appropriation is in addition to any other appropriation for food shelf programs under Minnesota Statutes, section 256E.34. This is a onetime appropriation.

(e) **Base Level Adjustment.** The general fund base is $22,065,000 in fiscal year 2022 and 22,065,000 in fiscal year 2023.

Subd. 26. **Grant Programs; Health Care Grants**

| | Appropriations by Fund | |
|---|---|---|
| General | 4,711,000 | 3,711,000 |
| State Government Special Revenue | 10,340,000 | 10,340,000 |
| Health Care Access | 3,465,000 | 3,465,000 |

Subd. 27. **Grant Programs; Other Long-Term Care Grants** 1,925,000 1,925,000

Subd. 28. **Grant Programs; Aging and Adult Services Grants** 31,811,000 31,995,000

Subd. 29. **Grant Programs; Deaf and Hard-of-Hearing Grants** 2,886,000 2,886,000

Subd. 30. **Grant Programs; Disabilities Grants** 22,231,000 22,944,000

(a) **Training of Direct Support Services Providers.** $375,000 in fiscal year 2020 and $375,000 in fiscal year 2021 are for stipends to pay for training of individual providers of direct support services as defined in Minnesota Statutes, section 256B.0711, subdivision 1. This training is available to individual providers who have completed designated voluntary trainings made available through the State Service Employees International Union Healthcare Minnesota Committee. This is a onetime appropriation. This appropriation is available only if the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved under Minnesota Statutes, section 3.855.

(b) **Training for New Worker Orientation.** $125,000 in fiscal year 2020 and $125,000 in fiscal year 2021 are for new worker orientation training and is allocated to the Minnesota State Service Employees International Union Healthcare Minnesota Committee. This is a onetime appropriation. This appropriation is available only if the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved under Minnesota Statutes, section 3.855.

(c) **Benefits Planning Grants.** $600,000 in fiscal year 2020 and $600,000 in fiscal year 2021 are to provide grant funding to the

Disability Hub for benefits planning to people with disabilities.

(d) **Regional Support for Person-Centered Practices Grants.** $374,000 in fiscal year 2020 and $486,000 in fiscal year 2021 are to extend and expand regional capacity for person-centered planning. This grant funding must be allocated to regional cohorts for training, coaching, and mentoring for person-centered and collaborative safety practices benefiting people with disabilities, and employees, organizations, and communities serving people with disabilities.

(e) **Disability Hub for Families Grants.** $100,000 in fiscal year 2020 and $200,000 in fiscal year 2021 are for grants to connect families through innovation grants, life planning tools, and website information as they support a child or family member with disabilities.

(f) **Electronic Visit Verification.** $500,000 in fiscal year 2021 is for grants to providers who use a different vendor than the contract with the State of Minnesota for electronic visit verification.

(g) **Base Level Adjustment.** The general fund base is $22,556,000 in fiscal year 2022 and $22,168,000 in fiscal year 2023.

| | | |
|---|---|---|
| Subd. 31. **Grant Programs; Housing Support Grants** | 10,764,000 | 11,864,000 |

(a) **Homeless Youth Act.** $750,000 in fiscal year 2020 and $750,000 in fiscal year 2021 are to provide grants under Minnesota Statutes,

section 256K.45. This appropriation is added to the base.

(b) **Emergency Services Grants.** $500,000 in fiscal year 2020 and $500,000 in fiscal year 2021 are to provide emergency services grants under Minnesota Statutes, section 256E.36. This appropriation is added to the base.

(c) **Long-Term Homeless Supportive Services.** $250,000 in fiscal year 2020 and $250,000 in fiscal year 2021 are to provide integrated services needed to stabilize individuals, families, and youth living in supportive housing under Minnesota Statutes, section 256K.26. This appropriation is added to the base.

Subd. 32. **Grant Programs; Adult Mental Health Grants**

| | Appropriations by Fund | |
|---|---|---|
| General | 80,723,000 | 80,292,000 |
| Health Care Access | 750,000 | 750,000 |

(a) **Certified Community Behavioral Health Center (CCBHC) Expansion.** $200,000 in fiscal year 2021 is from the general fund for grants for planning, staff training, and other quality improvements that are required to comply with federal CCBHC criteria for three expansion sites.

(b) **Center for Victims of Torture.** $500,000 in fiscal year 2020 and $500,000 in fiscal year 2021 are from the general fund for a grant to the Center for Victims of Torture. This grant may be used to fund start-up and additional operating costs for one site to employ the integrated care model for mental health targeted case management.

(c) **Mental Health Consultation.** $500,000 in fiscal year 2020 and $500,000 in fiscal year 2021 are from the general fund for grants to organizations to provide culturally specific mental health and substance use disorder consultation, to foster connections between the mental health and substance use disorder communities and cultural and ethnic communities. Culturally specific provider consultation includes:

(1) having available as a resource to other providers, a provider who understands the client's culture and can utilize that understanding to a client's benefit;

(2) providing regular consultation to mental health and substance use disorder treatment providers serving families from cultural and ethnic communities; and

(3) providing culturally appropriate referrals for services for parents and children with mental health conditions and substance use disorders.

(d) **Mobile Crisis Program.** $415,000 in fiscal year 2020 and $415,000 in fiscal year 2021 are from the general fund for a grant to Olmsted County under Minnesota Statutes, section 245.4661, to fund the administration of mobile mental health crisis services provided by the Southeast Mobile Crisis Team.

(e) **Recovery Community Organizations Grants.** $500,000 in fiscal year 2020 and $500,000 in fiscal year 2021 are from the general fund for grants to recovery community organizations to provide community-based

peer recovery support services that are not otherwise eligible for reimbursement under Minnesota Statutes, section 254B.05, including but not limited to training, hiring, and supervising recovery peers and peer specialists as part of the continuum of care for substance use disorders. This is a onetime appropriation.

(f) **Base Level Adjustment.** The general fund base is $78,592,000 in fiscal year 2022 and $78,592,000 in fiscal year 2023.

Subd. 33. **Grant Programs; Child Mental Health Grants** 25,726,000 25,726,000

(a) **Children's Intensive Services Reform.** $400,000 in fiscal year 2020 and $400,000 in fiscal year 2021 are for start-up grants to prospective psychiatric residential treatment facility sites for administrative expenses, consulting services, Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance, therapeutic resources including evidence-based, culturally appropriate curriculums, and training programs for staff and clients as well as allowable physical renovations to the property.

(b) **Base Level Adjustment.** The general fund base is $26,226,000 in fiscal year 2022 and $26,226,000 in fiscal year 2023.

Subd. 34. **Grant Programs; Chemical Dependency Treatment Support Grants**

| Appropriations by Fund | | |
|---|---|---|
| General | 2,636,000 | 2,636,000 |
| Lottery Prize | 1,733,000 | 1,733,000 |

(a) **Problem Gambling.** $225,000 in fiscal year 2020 and $225,000 in fiscal year 2021 are from the lottery prize fund for a grant to

the state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research related to problem gambling.

(b) **Grant to Proof Alliance.** (1) $500,000 in fiscal year 2020 and $500,000 in fiscal year 2021 are from the general fund for a grant to Proof Alliance. These appropriations are in addition to base level funding for this purpose. Of this appropriation, Proof Alliance shall make grants to eligible regional collaboratives for the purposes specified in clause (3).

(2) "Eligible regional collaboratives" means a partnership between at least one local government and at least one community-based organization and, where available, a family home visiting program. For purposes of this clause, a local government includes a county or multicounty organization, a tribal government, a county-based purchasing entity, or a community health board.

(3) Eligible regional collaboratives must use grant funds to reduce the incidence of fetal alcohol spectrum disorders and other prenatal drug-related effects in children in Minnesota by identifying and serving pregnant women suspected of or known to use or abuse alcohol or other drugs. Eligible regional collaboratives must provide intensive services to chemically dependent women to increase positive birth outcomes.

(4) Proof Alliance must make grants to eligible regional collaboratives from both rural and urban areas of the state.

(5) An eligible regional collaborative that receives a grant under this paragraph must report to Proof Alliance by January 15 of each year on the services and programs funded by the grant. The report must include measurable outcomes for the previous year, including the number of pregnant women served and the number of toxic-free babies born. Proof Alliance must compile the information in these reports and report that information to the commissioner of human services by February 15 of each year.

Subd. 35. **Direct Care and Treatment - Generally**

(a) **Transfer Authority.** Money appropriated to budget activities under this subdivision and subdivisions 36, 37, 38, and 39 may be transferred between budget activities and between years of the biennium with the approval of the commissioner of management and budget.

(b) **State Operated Services Account.** Any balance remaining in the state operated services account at the end of fiscal year 2019 shall be transferred to the general fund.

Subd. 36. **Direct Care and Treatment - Mental Health and Substance Abuse** 129,209,000 129,201,000

(a) **Transfer Authority.** Money previously appropriated to support the continued operations of the Community Addiction Enterprise (C.A.R.E.) program may be transferred to the enterprise fund for C.A.R.E.

(b) **Base Level Adjustment.** The general fund base is $129,197,000 in fiscal year 2022 and $129,197,000 in fiscal year 2023.

Subd. 37. **Direct Care and Treatment - Community-Based Services** 16,630,000 17,177,000

(a) **Transfer Authority.** Money previously appropriated to support the continued operations of the Minnesota State Operated Community Services (MSOCS) program may be transferred to the enterprise fund for MSOCS.

(b) **MSOCS Operating Adjustment.** $1,594,000 in fiscal year 2020 and $3,729,000 in fiscal year 2021 are from the general fund for the Minnesota State Operated Community Services program. The commissioner shall transfer $1,594,000 in fiscal year 2020 and $3,729,000 in fiscal year 2021 to the enterprise fund for MSOCS.

(c) **Base Level Adjustment.** The general fund base is $17,176,000 in fiscal year 2022 and $17,176,000 in fiscal year 2023.

Subd. 38. **Direct Care and Treatment - Forensic Services** 112,126,000 115,342,000

**Base Level Adjustment.** The general fund base is $115,944,000 in fiscal year 2022 and $115,944,000 in fiscal year 2023.

Subd. 39. **Direct Care and Treatment - Sex Offender Program** 97,072,000 97,621,000

(a) **Transfer Authority.** Money appropriated for the Minnesota sex offender program may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

(b) **Base Level Adjustment.** The general fund base is $98,166,000 in fiscal year 2022 and $98,166,000 in fiscal year 2023.

Subd. 40. **Direct Care and Treatment - Operations** 47,398,000 47,657,000

**Base Level Adjustment.** The general fund base is $47,656,000 in fiscal year 2022 and $47,656,000 in fiscal year 2023.

Subd. 41. **Technical Activities** 95,781,000 96,008,000

(a) **Generally.** This appropriation is from the federal TANF fund.

(b) **Base Level Adjustment.** The TANF fund base is $96,360,000 in fiscal year 2022 and $96,620,000 in fiscal year 2023.

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$ 250,590,000 $ 253,568,000**

Appropriations by Fund

| | 2020 | 2021 |
|---|---|---|
| General | 141,180,000 | 143,397,000 |
| State Government Special Revenue | 60,979,000 | 62,630,000 |
| Health Care Access | 36,718,000 | 35,828,000 |
| Federal TANF | 11,713,000 | 11,713,000 |

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Health Improvement**

Appropriations by Fund

| | | |
|---|---|---|
| General | 101,695,000 | 100,295,000 |
| State Government Special Revenue | 10,500,000 | 9,474,000 |
| Health Care Access | 36,718,000 | 35,828,000 |
| Federal TANF | 11,713,000 | 11,713,000 |

(a) **TANF Appropriations.** (1) $3,579,000 of the TANF fund each year is for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1;

(2) $2,000,000 of the TANF fund each year is for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7;

(3) $4,978,000 of the TANF fund each year is for the family home visiting grant program according to Minnesota Statutes, section 145A.17. $4,000,000 of the funding must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding must be distributed to tribal governments according to Minnesota Statutes, section 145A.14, subdivision 2a;

(4) $1,156,000 of the TANF fund each year is for family planning grants under Minnesota Statutes, section 145.925; and

(5) The commissioner may use up to 6.23 percent of the funds appropriated each year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

(b) **TANF Carryforward.** Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

(c) **Comprehensive Suicide Prevention.** $3,730,000 each fiscal year from the general fund is to support a comprehensive, community-based suicide prevention strategy. The funds are allocated as follows:

(1) $1,291,000 each fiscal year is for community-based suicide prevention grants authorized in Minnesota Statutes, section 145.56, subdivision 2. Specific emphasis must be placed on those communities with the greatest disparities;

(2) $913,000 each fiscal year is to support evidence-based training for educators and school staff and purchase suicide prevention curriculum for student use statewide, as authorized in Minnesota Statutes, section 145.56, subdivision 2;

(3) $205,000 each fiscal year is to implement the Zero Suicide framework with up to 20 behavioral and health care organizations each year to treat individuals at risk for suicide and support those individuals across systems of care upon discharge;

(4) $1,321,000 each fiscal year is to develop and fund a Minnesota-based network of National Suicide Prevention Lifeline, providing statewide coverage; and

(5) the commissioner may retain up to 18.23 percent of the appropriation under this

subdivision to administer the comprehensive suicide prevention strategy.

(d) **Statewide Tobacco Cessation.** $1,598,000 in fiscal year 2020 and $2,748,000 in fiscal year 2021 are from the general fund to the commissioner of health for statewide tobacco cessation services under Minnesota Statutes, section 144.397. The general fund base for this activity is $2,878,000 in fiscal year 2022 and $2,878,000 in fiscal year 2023.

(e) **Health Care Access Survey.** $450,000 in fiscal year 2020 is from the health care access fund for the commissioner to continue and improve the Minnesota Health Care Access Survey. This appropriation is added to the department's base budget for even-numbered fiscal years.

(f) **Community Solutions for Healthy Child Development Grant Program.** $2,000,000 in fiscal year 2020 is for the community solutions for healthy child development grant program to promote health and racial equity for young children and their families under Minnesota Statutes, section 145.9285. The commissioner may use up to 23.5 percent of the total appropriation for administration. This is a onetime appropriation and is available until June 30, 2023.

(g) **Palliative Care Advisory Council.** $44,000 in fiscal year 2020 and $44,000 in fiscal year 2021 are from the general fund for the Palliative Care Advisory Council under Minnesota Statutes, section 144.059. This is a onetime appropriation.

(h) **Domestic Violence and Sexual Assault Prevention Program.** $750,000 in fiscal year 2020 and $750,000 in fiscal year 2021 are from the general fund for purposes of the domestic violence and sexual assault prevention program under Minnesota Statutes, section 145.987. This is a onetime appropriation.

(i) **Comprehensive Advanced Life Support Educational Program.** $100,000 in fiscal year 2020 and $100,000 in fiscal year 2021 are from the general fund for the comprehensive advanced life support educational program under Minnesota Statutes, section 144.6062. These appropriations are in addition to base funding for the program in fiscal years 2020 and 2021.

(j) **Provider Network Adequacy Reviews.** $231,000 in fiscal year 2020 and $231,000 in fiscal year 2021 are from the general fund for health plan product reviews and licensing of health maintenance organizations. The $77,000 annual transfer from the state government special revenue fund to the general fund required by Laws 2008, chapter 364, section 17, paragraph (b), shall end in fiscal year 2019.

(k) **Network Adequacy Waiver Application Review Process.** $235,000 in fiscal year 2020 and $153,000 in fiscal year 2021 are from the general fund for review of network adequacy waiver applications and review of provider networks for health maintenance organizations and for health carriers offering individual and small group health plans.

(l) **Sexually Exploited Youth and Youth At Risk of Sexual Exploitation.** $250,000 in fiscal year 2020 and $250,000 in fiscal year 2021 are from the general fund for trauma-informed, culturally specific services for sexually exploited youth under the safe harbor program. Youth 24 years of age or younger are eligible for services under this paragraph. This is a onetime appropriation.

(m) **Home Visiting.** $250,000 in fiscal year 2020 and $250,000 in fiscal year 2021 are from the general fund for home visiting programs under Minnesota Statutes, section 145.87. This is a onetime appropriation.

(n) **The TAP Program.** $5,000 in fiscal year 2020 is for transfer to The TAP in St. Paul to support mental health in disability communities through spoken art forms, community support, and community engagement. This is a onetime appropriation.

(o) **Skin Lightening Products Public Awareness Grant Program.** $200,000 in fiscal year 2020 and $200,000 in fiscal year 2021 are from the general fund for a skin lightening products public awareness and education grant program. This is a onetime appropriation.

(p) **Health Care Financing System Analysis.** $500,000 in fiscal year 2020 is from the general fund for the commissioner to contract with the University of Minnesota to conduct an analysis of a unified health care financing system.

(q) **Base Level Adjustments.** The general fund base is $98,851,000 in fiscal year 2022 and $98,901,000 in fiscal year 2023. The health care access fund base is $36,878,000 in fiscal year 2022 and $35,828,000 in fiscal year 2023.

Subd. 3. **Health Protection**

| | Appropriations by Fund | |
|---|---|---|
| General | 28,673,000 | 32,190,000 |
| State Government Special Revenue | 50,479,000 | 53,156,000 |

(a) **Vulnerable Adults Program Improvements.** $7,438,000 in fiscal year 2020 and $4,302,000 in fiscal year 2021 are from the general fund for the commissioner to continue necessary current operations improvements to the regulatory activities, systems, analysis, reporting, and communications that contribute to the health, safety, care quality, and abuse prevention for vulnerable adults in Minnesota. $1,103,000 in fiscal year 2020 and $1,103,000 in fiscal year 2021 are from the state government special revenue fund to improve the frequency of home care provider inspections. The state government special revenue appropriations under this paragraph are onetime appropriations.

(b) **Vulnerable Adults Regulatory Reform.** $2,432,000 in fiscal year 2020 and $8,114,000 in fiscal year 2021 are from the general fund for the commissioner to establish the assisted living licensure under Minnesota Statutes, section 144I.01. This is a onetime appropriation. The commissioner shall transfer

fine revenue previously deposited to the state government special revenue fund under Minnesota Statutes, section 144A.474, subdivision 11, which is estimated to be $632,000, to a dedicated account in the state treasury.

(c) **Laboratory Equipment.** $840,000 in fiscal year 2020 and $655,000 in fiscal year 2021 are from the general fund for the commissioner to purchase equipment for the public health laboratory. These appropriations are onetime appropriations and available until June 30, 2023.

(d) **HIV Prevention Grants.** $500,000 in fiscal year 2020 and $500,000 in fiscal year 2021 are from the general fund for grants to community health boards as defined in Minnesota Statutes, section 145A.02, subdivision 5; tribal governments; and Minnesota nonprofit organizations for projects aimed at preventing the spread of HIV/AIDS, targeting communities in Minnesota at highest risk for HIV infection, and for individuals in Minnesota living with HIV/AIDS. Grants shall be awarded on a request for proposal basis and priority shall be given to community health boards, tribal governments, and organizations that have experience in dealing with issues related to HIV/AIDS. This is a onetime appropriation.

(e) **Regulation of Low-Dose X-Ray Security Screening Systems.** $86,000 in fiscal year 2020 and $58,000 in fiscal year 2021 are from the state government special revenue fund for rulemaking under Minnesota Statutes, section

144.121. The base for this appropriation is $31,000 in fiscal year 2022 and $31,000 in fiscal year 2023.

(f) **Base Level Adjustment.** The general fund base is $24,919,000 in fiscal year 2022 and $24,488,000 in fiscal year 2023. The state government special revenue fund base is $65,484,000 in fiscal year 2022 and $65,444,000 in fiscal year 2023.

| | | |
|---|---|---|
| Subd. 4. **Health Operations** | 10,812,000 | 10,912,000 |

Sec. 4. **HEALTH-RELATED BOARDS**

| | | |
|---|---|---|
| Subdivision 1. **Total Appropriation** | **$ 27,185,000** | **$ 26,576,000** |

This appropriation is from the state government special revenue fund unless specified otherwise. The amounts that may be spent for each purpose are specified in the following subdivisions.

| | | |
|---|---|---|
| Subd. 2. **Board of Chiropractic Examiners** | 629,000 | 641,000 |
| Subd. 3. **Board of Dentistry** | 1,503,000 | 1,450,000 |
| Subd. 4. **Board of Dietetics and Nutrition Practice** | 147,000 | 149,000 |
| Subd. 5. **Board of Marriage and Family Therapy** | 384,000 | 389,000 |

**Base Level Adjustment.** The base is $384,000 in fiscal year 2022 and $384,000 in fiscal year 2023.

| | | |
|---|---|---|
| Subd. 6. **Board of Medical Practice** | 6,013,000 | 5,996,000 |

(a) **Health Professional Services Program.** This appropriation includes $1,023,000 in fiscal year 2020 and $1,002,000 in fiscal year 2021 for the health professional services program.

(b) **Base Level Adjustment.** The base is $5,912,000 in fiscal year 2022 and $5,868,000 in fiscal year 2023.

| | | |
|---|---|---|
| Subd. 7. **Board of Nursing** | 4,993,000 | 4,993,000 |
| Subd. 8. **Board of Nursing Home Administrators** | 3,733,000 | 3,201,000 |

(a) **Administrative Services Unit - Operating Costs.** Of this appropriation, $3,445,000 in fiscal year 2020 and $2,910,000 in fiscal year 2021 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services it performs for other agencies.

(b) **Administrative Services Unit - Volunteer Health Care Provider Program.** Of this appropriation, $150,000 in fiscal year 2020 and $150,000 in fiscal year 2021 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

(c) **Administrative Services Unit - Retirement Costs.** Of this appropriation, $558,000 in fiscal year 2020 is a onetime appropriation to the administrative services unit to pay for the retirement costs of health-related board employees. This funding may be transferred to the health board incurring retirement costs. Any board that has an unexpended balance for an amount transferred under this paragraph shall transfer the unexpended amount to the administrative services unit. These funds are available either year of the biennium.

(d) **Administrative Services Unit - Contested Cases and Other Legal Proceedings.** Of this appropriation, $200,000 in fiscal year 2020 and $200,000 in fiscal year 2021 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification by a health-related board to the administrative services unit that costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of management and budget. The commissioner of management and budget must require any board that has an unexpended balance for an amount transferred under this paragraph to transfer the unexpended amount to the administrative services unit to be deposited in the state government special revenue fund.

| | | |
|---|---|---|
| Subd. 9. **Board of Optometry** | 200,000 | 201,000 |
| Subd. 10. **Board of Pharmacy** | 4,311,000 | 4,342,000 |
| Subd. 11. **Board of Physical Therapy** | 547,000 | 549,000 |
| Subd. 12. **Board of Podiatric Medicine** | 199,000 | 199,000 |
| Subd. 13. **Board of Psychology** | 1,357,000 | 1,395,000 |

**Base Level Adjustment.** The base is $1,355,000 in fiscal year 2022 and $1,355,000 in fiscal year 2023.

| | | |
|---|---|---|
| Subd. 14. **Board of Social Work** | 1,437,000 | 1,404,000 |
| Subd. 15. **Board of Veterinary Medicine** | 345,000 | 353,000 |

Subd. 16. **Board of Behavioral Health and Therapy** 937,000 858,000

**Base Level Adjustment.** The base is $833,000 in fiscal year 2022 and $833,000 in fiscal year 2023.

Subd. 17. **Board of Occupational Therapy Practice** 450,000 456,000

Sec. 5. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD** **$ 3,747,000 $ 3,809,000**

(a) **Cooper/Sams Volunteer Ambulance Program.** $950,000 in fiscal year 2020 and $950,000 in fiscal year 2021 are for the Cooper/Sams volunteer ambulance program under Minnesota Statutes, section 144E.40.

(1) Of this amount, $861,000 in fiscal year 2020 and $861,000 in fiscal year 2021 are for the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(2) Of this amount, $89,000 in fiscal year 2020 and $89,000 in fiscal year 2021 are for the operations of the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(b) **EMSRB Operations.** $1,851,000 in fiscal year 2020 and $1,913,000 in fiscal year 2021 are for board operations. The base for this program is $1,880,000 in fiscal year 2022 and $1,880,000 in fiscal year 2023.

(c) **Regional Grants.** $585,000 in fiscal year 2020 and $585,000 in fiscal year 2021 are for regional emergency medical services programs, to be distributed equally to the eight emergency medical service regions under Minnesota Statutes, section 144E.52.

(d) **Ambulance Training Grant.** $585,000 in fiscal year 2020 and $585,000 in fiscal year 2021 are for training grants under Minnesota Statutes, section 144E.35.

(e) **Base Level Adjustment.** The base is $3,776,000 in fiscal year 2022 and $3,776,000 in fiscal year 2023.

Sec. 6. **COUNCIL ON DISABILITY** **$ 1,014,000 $ 1,006,000**

Sec. 7. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 2,438,000 $ 2,438,000**

**Department of Psychiatry Monitoring.** $100,000 in fiscal year 2020 and $100,000 in fiscal year 2021 are for monitoring the Department of Psychiatry at the University of Minnesota.

Sec. 8. **OMBUDSPERSONS FOR FAMILIES** **$ 714,000 $ 723,000**

Sec. 9. **COMMISSIONER OF COMMERCE** **$ 764,000 $ 786,000**

(a) **Pharmacy Benefit Manager Licensing.** $277,000 in fiscal year 2020 and $274,000 in fiscal year 2021 are from the general fund for licensing activities under Minnesota Statutes, chapter 62W. The base for this appropriation is $274,000 in fiscal year 2022 and $274,000 in fiscal year 2023. $246,000 each year shall be used solely for staff costs for two enforcement investigators solely for enforcement activities under Minnesota Statutes, chapter 62W.

(b) **Base Level Adjustment.** The base is $815,000 in fiscal year 2022 and $843,000 in fiscal year 2023.

Sec. 10. **MNSURE BOARD** **$ 9,293,000 $ 4,539,000**

(a) **Generally.** These appropriations are from the health care access fund.

(b) **State-Based Premium Tax Credit.** $1,241,000 in fiscal year 2020 and $4,539,000 in fiscal year 2021 are for technology and program development and administration related to management and implementation of the advanced state-based health insurance premium tax credit. This is a onetime appropriation.

(c) **Premium Subsidy Program.** $8,052,000 in fiscal year 2020 is for administration of the premium subsidy program in Minnesota Statutes, chapter 62V. This is a onetime appropriation.

Sec. 11. **TRANSFERS; PREMIUM SECURITY ACCOUNT.**

(a) By August 30, 2020, the commissioner of commerce shall transfer $142,000,000 from the premium security account to the general fund. This is a onetime transfer.

(b) By August 30, 2020, the commissioner of commerce shall transfer $393,588,000 from the premium security account to the health care access fund. This is a onetime transfer.

Sec. 12. **RETURN OF PAYMENTS FOR JENSEN SETTLEMENT COSTS.**

Any money not used for payment of court-ordered costs or money returned by the court in United States District Court, case 0:09-cv-01775-DWF-BRT, Jensen et al. v. Minnesota Department of Human Services et al., is appropriated to the commissioner of human services for expenses related to direct care and treatment programs and notwithstanding any other provision is available until June 30, 2020.

Sec. 13. **TRANSFERS; HUMAN SERVICES.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2021, within fiscal years among the MFIP, general assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental aid program, group residential housing

program, the entitlement portion of Northstar Care for Children under Minnesota Statutes, chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Departments of Health and Human Services as the commissioners consider necessary, with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Sec. 14. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioners of health and human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 15. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2021, unless a different expiration date is explicit.

Sec. 16. **EFFECTIVE DATE.**

This article is effective July 1, 2019, unless a different effective date is specified.

**62A.021 HEALTH CARE POLICY RATES.**

Subdivision 1. **Loss ratio standards.** (a) Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, and except as otherwise authorized by section 62A.02, subdivision 3a, for individual policies or certificates, health care policies or certificates shall not be delivered or issued for delivery to an individual or to a small employer as defined in section 62L.02, unless the policies or certificates can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to Minnesota policyholders and certificate holders in the form of aggregate benefits not including anticipated refunds or credits, provided under the policies or certificates, (1) at least 75 percent of the aggregate amount of premiums earned in the case of policies issued in the small employer market, as defined in section 62L.02, subdivision 27, calculated on an aggregate basis; and (2) at least 65 percent of the aggregate amount of premiums earned in the case of each policy form or certificate form issued in the individual market; calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and according to accepted actuarial principles and practices. Assessments by the reinsurance association created in chapter 62L and all types of taxes, surcharges, or assessments created by Laws 1992, chapter 549, or created on or after April 23, 1992, are included in the calculation of incurred claims experience or incurred health care expenses. The applicable percentage for policies and certificates issued in the small employer market, as defined in section 62L.02, increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until an 82 percent loss ratio is reached on July 1, 2000. The applicable percentage for policy forms and certificate forms issued in the individual market increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until a 72 percent loss ratio is reached on July 1, 2000. A health carrier that enters a market after July 1, 1993, does not start at the beginning of the phase-in schedule and must instead comply with the loss ratio requirements applicable to other health carriers in that market for each time period. Premiums earned and claims incurred in markets other than the small employer and individual markets are not relevant for purposes of this section.

(b) All filings of rates and rating schedules shall demonstrate that actual expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards, and aggregate loss ratio from inception of the policy form or certificate form shall equal or exceed the appropriate loss ratio standards.

(c) A health carrier that issues health care policies and certificates to individuals or to small employers, as defined in section 62L.02, in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy form or certificate form duration for approval by the commissioner according to the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. If the data submitted does not confirm that the health carrier has satisfied the loss ratio requirements of this section, the commissioner shall notify the health carrier in writing of the deficiency. The health carrier shall have 30 days from the date of the commissioner's notice to file amended rates that comply with this section. If the health carrier fails to file amended rates within the prescribed time, the commissioner shall order that the health carrier's filed rates for the nonconforming policy form or certificate form be reduced to an amount that would have resulted in a loss ratio that complied with this section had it been in effect for the reporting period of the supplement. The health carrier's failure to file amended rates within the specified time or the issuance of the commissioner's order amending the rates does not preclude the health carrier from filing an amendment of its rates at a later time. The commissioner shall annually make the submitted data available to the public at a cost not to exceed the cost of copying. The data must be compiled in a form useful for consumers who wish to compare premium charges and loss ratios.

(d) Each sale of a policy or certificate that does not comply with the loss ratio requirements of this section is an unfair or deceptive act or practice in the business of insurance and is subject to the penalties in sections 72A.17 to 72A.32.

(e)(1) For purposes of this section, health care policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

(2) For purposes of this section, (i) "health care policy" or "health care certificate" is a health plan as defined in section 62A.011; and (ii) "health carrier" has the meaning given in section 62A.011 and includes all health carriers delivering or issuing for delivery health care policies or certificates in this state or offering these policies or certificates to residents of this state.

(f) The loss ratio phase-in as described in paragraph (a) does not apply to individual policies and small employer policies issued by a health plan company that is assessed less than three percent of the total annual amount assessed by the Minnesota Comprehensive Health Association. These policies must meet a 68 percent loss ratio for individual policies, a 71 percent loss ratio for small employer policies with fewer than ten employees, and a 75 percent loss ratio for all other small employer policies.

(g) Notwithstanding paragraphs (a) and (f), the loss ratio shall be 60 percent for a health plan as defined in section 62A.011, offered by an insurance company licensed under chapter 60A that is assessed less than ten percent of the total annual amount assessed by the Minnesota Comprehensive Health Association. For purposes of the percentage calculation of the association's assessments, an insurance company's assessments include those of its affiliates.

(h) The commissioners of commerce and health shall each annually issue a public report listing, by health plan company, the actual loss ratios experienced in the individual and small employer markets in this state by the health plan companies that the commissioners respectively regulate. The commissioners shall coordinate release of these reports so as to release them as a joint report or as separate reports issued the same day. The report or reports shall be released no later than June 1 for loss ratios experienced for the preceding calendar year. Health plan companies shall provide to the commissioners any information requested by the commissioners for purposes of this paragraph.

Subd. 3. **Loss ratio disclosure.** (a) Each health care policy form or health care certificate form for which subdivision 1 requires compliance with a loss ratio requirement shall prominently display the disclosure provided in paragraph (b) on its declarations sheet if it has one and, if not, on its front page. The disclosure must also be prominently displayed in any marketing materials used in connection with it.

(b) The disclosure must be in the following format:

Notice: This disclosure is required by Minnesota law. This policy or certificate is expected to return on average (fill in anticipated loss ratio approved by the commissioner) percent of your premium dollar for health care. The lowest percentage permitted by state law for this policy or certificate is (fill in applicable minimum loss ratio).

(c) This subdivision applies to policies and certificates issued on or after January 1, 1998.

**119B.125 PROVIDER REQUIREMENTS.**

Subd. 8. **Overpayment claim for failure to comply with access to records requirement.** (a) In establishing an overpayment claim under subdivision 6 for failure to provide access to attendance records, the county or commissioner is limited to the six years prior to the date the county or the commissioner requested the attendance records.

(b) When the commissioner or county establishes an overpayment claim against a current or former provider, the commissioner or county must provide notice of the claim to the provider. A notice of overpayment claim must specify the reason for the overpayment, the authority for making the overpayment claim, the time period in which the overpayment occurred, the amount of the overpayment, and the provider's right to appeal.

(c) The commissioner or county may seek to recover overpayments paid to a current or former provider. When a provider has been convicted of fraud under section 256.98, theft under section 609.52, or a federal crime relating to theft of state funds or fraudulent billing for a program administered by the commissioner or a county, recovery may be sought regardless of the amount of overpayment.

**119B.16 FAIR HEARING PROCESS.**

Subd. 2. **Informal conference.** The county agency shall offer an informal conference to applicants and recipients adversely affected by an agency action to attempt to resolve the dispute. The county agency shall offer an informal conference to providers to whom the county agency has assigned responsibility for an overpayment in an attempt to resolve the dispute. The county agency or the provider may ask the family in whose case the overpayment arose to participate in the informal conference, but the family may refuse to do so. The county agency shall advise adversely affected

applicants, recipients, and providers that a request for a conference with the agency is optional and does not delay or replace the right to a fair hearing.

**144.414 PROHIBITIONS.**

Subd. 5. **Electronic cigarettes.** (a) The use of electronic cigarettes, including the inhaling or exhaling of vapor from any electronic delivery device, as defined in section 609.685, subdivision 1, is prohibited in the following locations:

(1) any building owned or operated by the state, home rule charter or statutory city, county, township, school district, or other political subdivision;

(2) any facility owned by Minnesota State Colleges and Universities and the University of Minnesota;

(3) any facility licensed by the commissioner of human services; or

(4) any facility licensed by the commissioner of health, but only if the facility is also subject to federal licensing requirements.

(b) Nothing in this subdivision shall prohibit political subdivisions or businesses from adopting more stringent prohibitions on the use of electronic cigarettes or electronic delivery devices.

**144A.071 MORATORIUM ON CERTIFICATION OF NURSING HOME BEDS.**

Subd. 4d. **Consolidation of nursing facilities.** (a) The commissioner of health, in consultation with the commissioner of human services, may approve a request for consolidation of nursing facilities which includes the closure of one or more facilities and the upgrading of the physical plant of the remaining nursing facility or facilities, the costs of which exceed the threshold project limit under subdivision 2, clause (a). The commissioners shall consider the criteria in this section, section 144A.073, and section 256R.40, in approving or rejecting a consolidation proposal. In the event the commissioners approve the request, the commissioner of human services shall calculate an external fixed costs rate adjustment according to clauses (1) to (3):

(1) the closure of beds shall not be eligible for a planned closure rate adjustment under section 256R.40, subdivision 5;

(2) the construction project permitted in this clause shall not be eligible for a threshold project rate adjustment under section 256B.434, subdivision 4f, or a moratorium exception adjustment under section 144A.073; and

(3) the payment rate for external fixed costs for a remaining facility or facilities shall be increased by an amount equal to 65 percent of the projected net cost savings to the state calculated in paragraph (b), divided by the state's medical assistance percentage of medical assistance dollars, and then divided by estimated medical assistance resident days, as determined in paragraph (c), of the remaining nursing facility or facilities in the request in this paragraph. The rate adjustment is effective on the first day of the month of January or July, whichever date occurs first following both the completion of the construction upgrades in the consolidation plan and the complete closure of the facility or facilities designated for closure in the consolidation plan. If more than one facility is receiving upgrades in the consolidation plan, each facility's date of construction completion must be evaluated separately.

(b) For purposes of calculating the net cost savings to the state, the commissioner shall consider clauses (1) to (7):

(1) the annual savings from estimated medical assistance payments from the net number of beds closed taking into consideration only beds that are in active service on the date of the request and that have been in active service for at least three years;

(2) the estimated annual cost of increased case load of individuals receiving services under the elderly waiver;

(3) the estimated annual cost of elderly waiver recipients receiving support under housing support under chapter 256I;

(4) the estimated annual cost of increased case load of individuals receiving services under the alternative care program;

(5) the annual loss of license surcharge payments on closed beds;

(6) the savings from not paying planned closure rate adjustments that the facilities would otherwise be eligible for under section 256R.40; and

(7) the savings from not paying external fixed costs payment rate adjustments from submission of renovation costs that would otherwise be eligible as threshold projects under section 256B.434, subdivision 4f.

(c) For purposes of the calculation in paragraph (a), clause (3), the estimated medical assistance resident days of the remaining facility or facilities shall be computed assuming 95 percent occupancy multiplied by the historical percentage of medical assistance resident days of the remaining facility or facilities, as reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, multiplied by 365.

(d) For purposes of net cost of savings to the state in paragraph (b), the average occupancy percentages will be those reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, and the average payment rates shall be calculated based on the approved payment rates in effect at the time the consolidation request is submitted.

(e) To qualify for the external fixed costs payment rate adjustment under this subdivision, the closing facilities shall:

(1) submit an application for closure according to section 256R.40, subdivision 2; and

(2) follow the resident relocation provisions of section 144A.161.

(f) The county or counties in which a facility or facilities are closed under this subdivision shall not be eligible for designation as a hardship area under subdivision 3 for five years from the date of the approval of the proposed consolidation. The applicant shall notify the county of this limitation and the county shall acknowledge this in a letter of support.

**144A.441 ASSISTED LIVING BILL OF RIGHTS ADDENDUM.**

Assisted living clients, as defined in section 144G.01, subdivision 3, shall be provided with the home care bill of rights required by section 144A.44, except that the home care bill of rights provided to these clients must include the following provision in place of the provision in section 144A.44, subdivision 1, clause (17):

"(17) the right to reasonable, advance notice of changes in services or charges, including at least 30 days' advance notice of the termination of a service by a provider, except in cases where:

(i) the recipient of services engages in conduct that alters the conditions of employment as specified in the employment contract between the home care provider and the individual providing home care services, or creates an abusive or unsafe work environment for the individual providing home care services;

(ii) an emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the home care provider; or

(iii) the provider has not received payment for services, for which at least ten days' advance notice of the termination of a service shall be provided."

**144A.442 ASSISTED LIVING CLIENTS; SERVICE TERMINATION.**

If an arranged home care provider, as defined in section 144D.01, subdivision 2a, who is not also Medicare certified terminates a service agreement or service plan with an assisted living client, as defined in section 144G.01, subdivision 3, the home care provider shall provide the assisted living client and the legal or designated representatives of the client, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the reason for termination;

(3) without extending the termination notice period, an affirmative offer to meet with the assisted living client or client representatives within no more than five business days of the date of the termination notice to discuss the termination;

(4) contact information for a reasonable number of other home care providers in the geographic area of the assisted living client, as required by section 144A.4791, subdivision 10;

(5) a statement that the provider will participate in a coordinated transfer of the care of the client to another provider or caregiver, as required by section 144A.44, subdivision 1, clause (18);

(6) the name and contact information of a representative of the home care provider with whom the client may discuss the notice of termination;

(7) a copy of the home care bill of rights; and

(8) a statement that the notice of termination of home care services by the home care provider does not constitute notice of termination of the housing with services contract with a housing with services establishment.

**144A.45 REGULATION OF HOME CARE SERVICES.**

Subd. 6. **Home care providers; tuberculosis prevention and control.** (a) A home care provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

(b) Written compliance with this subdivision must be maintained by the home care provider.

**144A.472 HOME CARE PROVIDER LICENSE; APPLICATION AND RENEWAL.**

Subd. 4. **Multiple units.** Multiple units or branches of a licensee must be separately licensed if the commissioner determines that the units cannot adequately share supervision and administration of services from the main office.

**144A.481 HOME CARE LICENSING IMPLEMENTATION FOR NEW LICENSEES AND TRANSITION PERIOD FOR CURRENT LICENSEES.**

Subdivision 1. **Temporary home care licenses and changes of ownership.** (a) Beginning January 1, 2014, all temporary license applicants must apply for either a temporary basic or comprehensive home care license.

(b) Temporary home care licenses issued beginning January 1, 2014, shall be issued according to sections 144A.43 to 144A.4798, and the fees in section 144A.472. Temporary licensees must comply with the requirements of this chapter.

(c) No temporary license applications will be accepted nor temporary licenses issued between December 1, 2013, and December 31, 2013.

(d) Beginning October 1, 2013, changes in ownership applications will require payment of the new fees listed in section 144A.472. Providers who are providing nursing, delegated nursing, or professional health care services, must submit the fee for comprehensive home care providers, and all other providers must submit the fee for basic home care providers as provided in section 144A.472. Change of ownership applicants will be issued a new home care license based on the licensure law in effect on June 30, 2013.

Subd. 2. **Current home care licensees with licenses as of December 31, 2013.** (a) Beginning July 1, 2014, department licensed home care providers must apply for either the basic or comprehensive home care license on their regularly scheduled renewal date.

(b) By June 30, 2015, all home care providers must either have a basic or comprehensive home care license or temporary license.

Subd. 3. **Renewal application of home care licensure during transition period.** (a) Renewal and change of ownership applications of home care licenses issued beginning July 1, 2014, will be issued according to sections 144A.43 to 144A.4798 and, upon license renewal or issuance of a new license for a change of ownership, providers must comply with sections 144A.43 to 144A.4798. Prior to renewal, providers must comply with the home care licensure law in effect on June 30, 2013.

(b) The fees charged for licenses renewed between July 1, 2014, and June 30, 2016, shall be the lesser of 200 percent or $1,000, except where the 200 percent or $1,000 increase exceeds the actual renewal fee charged, with a maximum renewal fee of $6,625.

(c) For fiscal year 2014 only, the fees for providers with revenues greater than $25,000 and no more than $100,000 will be $313 and for providers with revenues no more than $25,000 the fee will be $125.

**144D.01 DEFINITIONS.**

Subdivision 1. **Scope.** As used in sections 144D.01 to 144D.06, the following terms have the meanings given them.

Subd. 2. **Adult.** "Adult" means a natural person who has attained the age of 18 years.

Subd. 2a. **Arranged home care provider.** "Arranged home care provider" means a home care provider licensed under chapter 144A that provides services to some or all of the residents of a housing with services establishment and that is either the establishment itself or another entity with which the establishment has an arrangement.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of health or the commissioner's designee.

Subd. 3a. **Direct-care staff.** "Direct-care staff" means staff and employees who provide home care services listed in section 144A.471, subdivisions 6 and 7.

Subd. 4. **Housing with services establishment or establishment.** (a) "Housing with services establishment" or "establishment" means:

(1) an establishment providing sleeping accommodations to one or more adult residents, at least 80 percent of which are 55 years of age or older, and offering or providing, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services, whether offered or provided directly by the establishment or by another entity arranged for by the establishment; or

(2) an establishment that registers under section 144D.025.

(b) Housing with services establishment does not include:

(1) a nursing home licensed under chapter 144A;

(2) a hospital, certified boarding care home, or supervised living facility licensed under sections 144.50 to 144.56;

(3) a board and lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D or 245G;

(4) a board and lodging establishment which serves as a shelter for battered women or other similar purpose;

(5) a family adult foster care home licensed by the Department of Human Services;

(6) private homes in which the residents are related by kinship, law, or affinity with the providers of services;

(7) residential settings for persons with developmental disabilities in which the services are licensed under chapter 245D;

(8) a home-sharing arrangement such as when an elderly or disabled person or single-parent family makes lodging in a private residence available to another person in exchange for services or rent, or both;

(9) a duly organized condominium, cooperative, common interest community, or owners' association of the foregoing where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units;

(10) services for persons with developmental disabilities that are provided under a license under chapter 245D; or

(11) a temporary family health care dwelling as defined in sections 394.307 and 462.3593.

Subd. 5. **Supportive services.** "Supportive services" means help with personal laundry, handling or assisting with personal funds of residents, or arranging for medical services, health-related services, social services, or transportation to medical or social services appointments. Arranging

for services does not include making referrals, assisting a resident in contacting a service provider of the resident's choice, or contacting a service provider in an emergency.

Subd. 6. **Health-related services.** "Health-related services" include professional nursing services, home health aide tasks, or the central storage of medication for residents.

Subd. 7. **Family adult foster care home.** "Family adult foster care home" means an adult foster care home that is licensed by the Department of Human Services, that is the primary residence of the license holder, and in which the license holder is the primary caregiver.

**144D.015 DEFINITION FOR PURPOSES OF LONG-TERM CARE INSURANCE.**

For purposes of consistency with terminology commonly used in long-term care insurance policies and notwithstanding chapter 144G, a housing with services establishment that is registered under section 144D.03 and that holds, or makes arrangements with an individual or entity that holds any type of home care license and all other licenses, permits, registrations, or other governmental approvals legally required for delivery of the services the establishment offers or provides to its residents, constitutes an "assisted living facility" or "assisted living residence."

**144D.02 REGISTRATION REQUIRED.**

No entity may establish, operate, conduct, or maintain a housing with services establishment in this state without registering and operating as required in sections 144D.01 to 144D.06.

**144D.025 OPTIONAL REGISTRATION.**

An establishment that meets all the requirements of this chapter except that fewer than 80 percent of the adult residents are age 55 or older, or a supportive housing establishment developed and funded in whole or in part with funds provided specifically as part of the plan to end long-term homelessness required under Laws 2003, chapter 128, article 15, section 9, may, at its option, register as a housing with services establishment.

**144D.03 REGISTRATION.**

Subdivision 1. **Registration procedures.** The commissioner shall establish forms and procedures for annual registration of housing with services establishments. The commissioner shall charge an annual registration fee of $155. No fee shall be refunded. A registered establishment shall notify the commissioner within 30 days of the date it is no longer required to be registered under this chapter or of any change in the business name or address of the establishment, the name or mailing address of the owner or owners, or the name or mailing address of the managing agent. There shall be no fee for submission of the notice.

Subd. 1a. **Surcharge for injunctive relief actions.** The commissioner shall assess each housing with services establishment that offers or provides assisted living under chapter 144G a surcharge on the annual registration fee paid under subdivision 1, to pay for the commissioner's costs related to bringing actions for injunctive relief under section 144G.02, subdivision 2, paragraph (b), on or after July 1, 2007. The commissioner shall assess surcharges using a sliding scale under which the surcharge amount increases with the client capacity of an establishment. The commissioner shall adjust the surcharge as necessary to recover the projected costs of bringing actions for injunctive relief. The commissioner shall adjust the surcharge in accordance with section 16A.1285.

Subd. 2. **Registration information.** The establishment shall provide the following information to the commissioner in order to be registered:

(1) the business name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners are not natural persons, identification of the type of business entity of the owner or owners, and the names and addresses of the officers and members of the governing body, or comparable persons for partnerships, limited liability corporations, or other types of business organizations of the owner or owners;

(3) the name and mailing address of the managing agent, whether through management agreement or lease agreement, of the establishment, if different from the owner or owners, and the name of the on-site manager, if any;

(4) verification that the establishment has entered into a housing with services contract, as required in section 144D.04, with each resident or resident's representative;

(5) verification that the establishment is complying with the requirements of section 325F.72, if applicable;

(6) the name and address of at least one natural person who shall be responsible for dealing with the commissioner on all matters provided for in sections 144D.01 to 144D.06, and on whom personal service of all notices and orders shall be made, and who shall be authorized to accept service on behalf of the owner or owners and the managing agent, if any;

(7) the signature of the authorized representative of the owner or owners or, if the owner or owners are not natural persons, signatures of at least two authorized representatives of each owner, one of which shall be an officer of the owner; and

(8) whether services are included in the base rate to be paid by the resident.

Personal service on the person identified under clause (6) by the owner or owners in the registration shall be considered service on the owner or owners, and it shall not be a defense to any action that personal service was not made on each individual or entity. The designation of one or more individuals under this subdivision shall not affect the legal responsibility of the owner or owners under sections 144D.01 to 144D.06.

**144D.04 HOUSING WITH SERVICES CONTRACTS.**

Subdivision 1. **Contract required.** No housing with services establishment may operate in this state unless a written housing with services contract, as defined in subdivision 2, is executed between the establishment and each resident or resident's representative and unless the establishment operates in accordance with the terms of the contract. The resident or the resident's representative shall be given a complete copy of the contract and all supporting documents and attachments and any changes whenever changes are made.

Subd. 2. **Contents of contract.** A housing with services contract, which need not be entitled as such to comply with this section, shall include at least the following elements in itself or through supporting documents or attachments:

(1) the name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;

(4) the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;

(5) a statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;

(6) the term of the contract;

(7) a description of the services to be provided to the resident in the base rate to be paid by the resident, including a delineation of the portion of the base rate that constitutes rent and a delineation of charges for each service included in the base rate;

(8) a description of any additional services, including home care services, available for an additional fee from the establishment directly or through arrangements with the establishment, and a schedule of fees charged for these services;

(9) a conspicuous notice informing the tenant of the policy concerning the conditions under which and the process through which the contract may be modified, amended, or terminated, including whether a move to a different room or sharing a room would be required in the event that the tenant can no longer pay the current rent;

(10) a description of the establishment's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;

(11) the resident's designated representative, if any;

(12) the establishment's referral procedures if the contract is terminated;

(13) requirements of residency used by the establishment to determine who may reside or continue to reside in the housing with services establishment;

(14) billing and payment procedures and requirements;

(15) a statement regarding the ability of a resident to receive services from service providers with whom the establishment does not have an arrangement;

(16) a statement regarding the availability of public funds for payment for residence or services in the establishment; and

(17) a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the establishment is located.

Subd. 2a. **Additional contract requirements.** (a) For a resident receiving one or more health-related services from the establishment's arranged home care provider, as defined in section 144D.01, subdivision 6, the contract must include the requirements in paragraph (b). A restriction of a resident's rights under this subdivision is allowed only if determined necessary for health and safety reasons identified by the home care provider's registered nurse in an initial assessment or reassessment, as defined under section 144A.4791, subdivision 8, and documented in the written service plan under section 144A.4791, subdivision 9. Any restrictions of those rights for people served under sections 256B.0915 and 256B.49 must be documented in the resident's coordinated service and support plan (CSSP), as defined under sections 256B.0915, subdivision 6 and 256B.49, subdivision 15.

(b) The contract must include a statement:

(1) regarding the ability of a resident to furnish and decorate the resident's unit within the terms of the lease;

(2) regarding the resident's right to access food at any time;

(3) regarding a resident's right to choose the resident's visitors and times of visits;

(4) regarding the resident's right to choose a roommate if sharing a unit; and

(5) notifying the resident of the resident's right to have and use a lockable door to the resident's unit. The landlord shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible.

Subd. 3. **Contracts in permanent files.** Housing with services contracts and related documents executed by each resident or resident's representative shall be maintained by the establishment in files from the date of execution until three years after the contract is terminated. The contracts and the written disclosures required under section 325F.72, if applicable, shall be made available for on-site inspection by the commissioner upon request at any time.

**144D.045 INFORMATION CONCERNING ARRANGED HOME CARE PROVIDERS.**

If a housing with services establishment has one or more arranged home care providers, the establishment shall arrange to have that arranged home care provider deliver the following information in writing to a prospective resident, prior to the date on which the prospective resident executes a contract with the establishment or the prospective resident's move-in date, whichever is earlier:

(1) the name, mailing address, and telephone number of the arranged home care provider;

(2) the name and mailing address of at least one natural person who is authorized to accept service of process on behalf of the entity described in clause (1);

(3) a description of the process through which a home care service agreement or service plan between a resident and the arranged home care provider, if any, may be modified, amended, or terminated;

(4) the arranged home care provider's billing and payment procedures and requirements; and

(5) any limits to the services available from the arranged provider.

**144D.05 AUTHORITY OF COMMISSIONER.**

The commissioner shall, upon receipt of information which may indicate the failure of the housing with services establishment, a resident, a resident's representative, or a service provider to comply with a legal requirement to which one or more of them may be subject, make appropriate referrals to other governmental agencies and entities having jurisdiction over the subject matter.

The commissioner may also make referrals to any public or private agency the commissioner considers available for appropriate assistance to those involved.

The commissioner shall have standing to bring an action for injunctive relief in the district court in the district in which an establishment is located to compel the housing with services establishment to meet the requirements of this chapter or other requirements of the state or of any county or local governmental unit to which the establishment is otherwise subject. Proceedings for securing an injunction may be brought by the commissioner through the attorney general or through the appropriate county attorney. The sanctions in this section do not restrict the availability of other sanctions.

**144D.06 OTHER LAWS.**

In addition to registration under this chapter, a housing with services establishment must comply with chapter 504B and the provisions of section 325F.72, and shall obtain and maintain all other licenses, permits, registrations, or other governmental approvals required of it. A housing with services establishment is not required to obtain a lodging license under chapter 157 and related rules.

**144D.065 TRAINING IN DEMENTIA CARE REQUIRED.**

(a) If a housing with services establishment registered under this chapter has a special program or special care unit for residents with Alzheimer's disease or other dementias or advertises, markets, or otherwise promotes the establishment as providing services for persons with Alzheimer's disease or other dementias, whether in a segregated or general unit, employees of the establishment and of the establishment's arranged home care provider must meet the following training requirements:

(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;

(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b), or a supervisor meeting the requirements in clause (1), must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;

(3) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and

(4) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months.

(b) Areas of required training include:

(1) an explanation of Alzheimer's disease and related disorders;

(2) assistance with activities of daily living;

(3) problem solving with challenging behaviors; and

(4) communication skills.

(c) The establishment shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This information satisfies the disclosure requirements of section 325F.72, subdivision 2, clause (4).

(d) Housing with services establishments not included in paragraph (a) that provide assisted living services under chapter 144G must meet the following training requirements:

(1) supervisors of direct-care staff must have at least four hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must

have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;

(2) direct-care employees must have completed at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial four hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or supervisor meeting the requirements under paragraph (a), clause (1), must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;

(3) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and

(4) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months.

**144D.066 ENFORCEMENT OF DEMENTIA CARE TRAINING REQUIREMENTS.**

Subdivision 1. **Enforcement.** (a) The commissioner shall enforce the dementia care training standards for staff working in housing with services settings and for housing managers according to clauses (1) to (3):

(1) for dementia care training requirements in section 144D.065, the commissioner shall review training records as part of the home care provider survey process for direct care staff and supervisors of direct care staff, in accordance with section 144A.474. The commissioner may also request and review training records at any time during the year;

(2) for dementia care training standards in section 144D.065, the commissioner shall review training records for maintenance, housekeeping, and food service staff and other staff not providing direct care working in housing with services settings as part of the housing with services registration application and renewal application process in accordance with section 144D.03. The commissioner may also request and review training records at any time during the year; and

(3) for housing managers, the commissioner shall review the statement verifying compliance with the required training described in section 144D.10, paragraph (d), through the housing with services registration application and renewal application process in accordance with section 144D.03. The commissioner may also request and review training records at any time during the year.

(b) The commissioner shall specify the required forms and what constitutes sufficient training records for the items listed in paragraph (a), clauses (1) to (3).

Subd. 2. **Fines for noncompliance.** (a) Beginning January 1, 2017, the commissioner may impose a $200 fine for every staff person required to obtain dementia care training who does not have training records to show compliance. For violations of subdivision 1, paragraph (a), clause (1), the fine will be imposed upon the home care provider, and may be appealed under the contested case procedure in section 144A.475, subdivisions 3a, 4, and 7. For violations of subdivision 1, paragraph (a), clauses (2) and (3), the fine will be imposed on the housing with services registrant and may be appealed under the contested case procedure in section 144A.475, subdivisions 3a, 4, and 7. Prior to imposing the fine, the commissioner must allow two weeks for staff to complete the required training. Fines collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

(b) The housing with services registrant and home care provider must allow for the required training as part of employee and staff duties. Imposition of a fine by the commissioner does not negate the need for the required training. Continued noncompliance with the requirements of sections 144D.065 and 144D.10 may result in revocation or nonrenewal of the housing with services registration or home care license. The commissioner shall make public the list of all housing with services establishments that have complied with the training requirements.

Subd. 3. **Technical assistance.** From January 1, 2016, to December 31, 2016, the commissioner shall provide technical assistance instead of imposing fines for noncompliance with the training requirements. During the year of technical assistance, the commissioner shall review the training

records to determine if the records meet the requirements and inform the home care provider. The commissioner shall also provide information about available training resources.

**144D.07 RESTRAINTS.**

Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience.

**144D.08 UNIFORM CONSUMER INFORMATION GUIDE.**

All housing with services establishments shall make available to all prospective and current residents information consistent with the uniform format and the required components adopted by the commissioner under section 144G.06. This section does not apply to an establishment registered under section 144D.025 serving the homeless.

**144D.09 TERMINATION OF LEASE.**

The housing with services establishment shall include with notice of termination of lease information about how to contact the ombudsman for long-term care, including the address and telephone number along with a statement of how to request problem-solving assistance.

**144D.10 MANAGER REQUIREMENTS.**

(a) The person primarily responsible for oversight and management of a housing with services establishment, as designated by the owner of the housing with services establishment, must obtain at least 30 hours of continuing education every two years of employment as the manager in topics relevant to the operations of the housing with services establishment and the needs of its tenants. Continuing education earned to maintain a professional license, such as nursing home administrator license, nursing license, social worker license, and real estate license, can be used to complete this requirement.

(b) For managers of establishments identified in section 325F.72, this continuing education must include at least eight hours of documented training on the topics identified in section 144D.065, paragraph (b), within 160 working hours of hire, and two hours of training on these topics for each 12 months of employment thereafter.

(c) For managers of establishments not covered by section 325F.72, but who provide assisted living services under chapter 144G, this continuing education must include at least four hours of documented training on the topics identified in section 144D.065, paragraph (b), within 160 working hours of hire, and two hours of training on these topics for each 12 months of employment thereafter.

(d) A statement verifying compliance with the continuing education requirement must be included in the housing with services establishment's annual registration to the commissioner of health. The establishment must maintain records for at least three years demonstrating that the person primarily responsible for oversight and management of the establishment has attended educational programs as required by this section.

(e) New managers may satisfy the initial dementia training requirements by producing written proof of previously completed required training within the past 18 months.

(f) This section does not apply to an establishment registered under section 144D.025 serving the homeless.

**144D.11 EMERGENCY PLANNING.**

(a) Each registered housing with services establishment must meet the following requirements:

(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in-place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;

(2) post an emergency disaster plan prominently;

(3) provide building emergency exit diagrams to all tenants upon signing a lease;

(4) post emergency exit diagrams on each floor; and

(5) have a written policy and procedure regarding missing tenants.

(b) Each registered housing with services establishment must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training available to all tenants annually. Staff who have not received

emergency and disaster training are allowed to work only when trained staff are also working on site.

(c) Each registered housing with services location must conduct and document a fire drill or other emergency drill at least every six months. To the extent possible, drills must be coordinated with local fire departments or other community emergency resources.

**144G.01 DEFINITIONS.**

Subdivision 1. **Scope; other definitions.** For purposes of sections 144G.01 to 144G.05, the following definitions apply. In addition, the definitions provided in section 144D.01 also apply to sections 144G.01 to 144G.05.

Subd. 2. **Assisted living.** "Assisted living" means a service or package of services advertised, marketed, or otherwise described, offered, or promoted using the phrase "assisted living" either alone or in combination with other words, whether orally or in writing, and which is subject to the requirements of this chapter.

Subd. 3. **Assisted living client; client.** "Assisted living client" or "client" means a housing with services resident who receives assisted living that is subject to the requirements of this chapter.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of health.

**144G.02 ASSISTED LIVING; PROTECTED TITLE; REGULATORY FUNCTION.**

Subdivision 1. **Protected title; restriction on use.** No person or entity may use the phrase "assisted living," whether alone or in combination with other words and whether orally or in writing, to advertise, market, or otherwise describe, offer, or promote itself, or any housing, service, service package, or program that it provides within this state, unless the person or entity is a housing with services establishment that meets the requirements of this chapter, or is a person or entity that provides some or all components of assisted living that meet the requirements of this chapter. A person or entity entitled to use the phrase "assisted living" shall use the phrase only in the context of its participation in assisted living that meets the requirements of this chapter. A housing with services establishment offering or providing assisted living that is not made available to residents in all of its housing units shall identify the number or location of the units in which assisted living is available, and may not use the term "assisted living" in the name of the establishment registered with the commissioner under chapter 144D, or in the name the establishment uses to identify itself to residents or the public.

Subd. 2. **Authority of commissioner.** (a) The commissioner, upon receipt of information that may indicate the failure of a housing with services establishment, the arranged home care provider, an assisted living client, or an assisted living client's representative to comply with a legal requirement to which one or more of the entities may be subject, shall make appropriate referrals to other governmental agencies and entities having jurisdiction over the subject matter. The commissioner may also make referrals to any public or private agency the commissioner considers available for appropriate assistance to those involved.

(b) In addition to the authority with respect to licensed home care providers under section 144A.45 and with respect to housing with services establishments under chapter 144D, the commissioner shall have standing to bring an action for injunctive relief in the district court in the district in which a housing with services establishment is located to compel the housing with services establishment or the arranged home care provider to meet the requirements of this chapter or other requirements of the state or of any county or local governmental unit to which the establishment or arranged home care provider is otherwise subject. Proceedings for securing an injunction may be brought by the commissioner through the attorney general or through the appropriate county attorney. The sanctions in this section do not restrict the availability of other sanctions.

**144G.03 ASSISTED LIVING REQUIREMENTS.**

Subdivision 1. **Verification in annual registration.** A registered housing with services establishment using the phrase "assisted living," pursuant to section 144G.02, subdivision 1, shall verify to the commissioner in its annual registration pursuant to chapter 144D that the establishment is complying with sections 144G.01 to 144G.05, as applicable.

Subd. 2. **Minimum requirements for assisted living.** (a) Assisted living shall be provided or made available only to individuals residing in a registered housing with services establishment. Except as expressly stated in this chapter, a person or entity offering assisted living may define the available services and may offer assisted living to all or some of the residents of a housing with services establishment. The services that comprise assisted living may be provided or made available

directly by a housing with services establishment or by persons or entities with which the housing with services establishment has made arrangements.

(b) A person or entity entitled to use the phrase "assisted living," according to section 144G.02, subdivision 1, shall do so only with respect to a housing with services establishment, or a service, service package, or program available within a housing with services establishment that, at a minimum:

(1) provides or makes available health-related services under a home care license. At a minimum, health-related services must include:

(i) assistance with self-administration of medication, medication management, or medication administration as defined in section 144A.43; and

(ii) assistance with at least three of the following seven activities of daily living: bathing, dressing, grooming, eating, transferring, continence care, and toileting.

All health-related services shall be provided in a manner that complies with applicable home care licensure requirements in chapter 144A and sections 148.171 to 148.285;

(2) provides necessary assessments of the physical and cognitive needs of assisted living clients by a registered nurse, as required by applicable home care licensure requirements in chapter 144A and sections 148.171 to 148.285;

(3) has and maintains a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by applicable home care licensure requirements in chapter 144A and sections 148.171 to 148.285;

(4) provides staff access to an on-call registered nurse 24 hours per day, seven days per week;

(5) has and maintains a system to check on each assisted living client at least daily;

(6) provides a means for assisted living clients to request assistance for health and safety needs 24 hours per day, seven days per week, from the establishment or a person or entity with which the establishment has made arrangements;

(7) has a person or persons available 24 hours per day, seven days per week, who is responsible for responding to the requests of assisted living clients for assistance with health or safety needs, who shall be:

(i) awake;

(ii) located in the same building, in an attached building, or on a contiguous campus with the housing with services establishment in order to respond within a reasonable amount of time;

(iii) capable of communicating with assisted living clients;

(iv) capable of recognizing the need for assistance;

(v) capable of providing either the assistance required or summoning the appropriate assistance; and

(vi) capable of following directions;

(8) offers to provide or make available at least the following supportive services to assisted living clients:

(i) two meals per day;

(ii) weekly housekeeping;

(iii) weekly laundry service;

(iv) upon the request of the client, reasonable assistance with arranging for transportation to medical and social services appointments, and the name of or other identifying information about the person or persons responsible for providing this assistance;

(v) upon the request of the client, reasonable assistance with accessing community resources and social services available in the community, and the name of or other identifying information about the person or persons responsible for providing this assistance; and

(vi) periodic opportunities for socialization; and

(9) makes available to all prospective and current assisted living clients information consistent with the uniform format and the required components adopted by the commissioner under section 144G.06. This information must be made available beginning no later than six months after the commissioner makes the uniform format and required components available to providers according to section 144G.06.

Subd. 3. **Exemption from awake-staff requirement.** A housing with services establishment that offers or provides assisted living is exempt from the requirement in subdivision 2, paragraph (b), clause (7), item (i), that the person or persons available and responsible for responding to requests for assistance must be awake, if the establishment meets the following requirements:

(1) the establishment has a maximum capacity to serve 12 or fewer assisted living clients;

(2) the person or persons available and responsible for responding to requests for assistance are physically present within the housing with services establishment in which the assisted living clients reside;

(3) the establishment has a system in place that is compatible with the health, safety, and welfare of the establishment's assisted living clients;

(4) the establishment's housing with services contract, as required by section 144D.04, includes a statement disclosing the establishment's qualification for, and intention to rely upon, this exemption;

(5) the establishment files with the commissioner, for purposes of public information but not review or approval by the commissioner, a statement describing how the establishment meets the conditions in clauses (1) to (4), and makes a copy of this statement available to actual and prospective assisted living clients; and

(6) the establishment indicates on its housing with services registration, under section 144D.02 or 144D.03, as applicable, that it qualifies for and intends to rely upon the exemption under this subdivision.

Subd. 4. **Nursing assessment.** (a) A housing with services establishment offering or providing assisted living shall:

(1) offer to have the arranged home care provider conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a service plan prior to the date on which a prospective resident executes a contract with a housing with services establishment or the date on which a prospective resident moves in, whichever is earlier; and

(2) inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a housing with services establishment or the date on which a prospective resident moves in, whichever is earlier.

(b) An arranged home care provider is not obligated to conduct a nursing assessment by a registered nurse when requested by a prospective resident if either the geographic distance between the prospective resident and the provider, or urgent or unexpected circumstances, do not permit the assessment to be conducted prior to the date on which the prospective resident executes a contract or moves in, whichever is earlier. When such circumstances occur, the arranged home care provider shall offer to conduct a telephone conference whenever reasonably possible.

(c) The arranged home care provider shall comply with applicable home care licensure requirements in chapter 144A and sections 148.171 to 148.285, with respect to the provision of a nursing assessment prior to the delivery of nursing services and the execution of a home care service plan or service agreement.

Subd. 5. **Assistance with arranged home care provider.** The housing with services establishment shall provide each assisted living client with identifying information about a person or persons reasonably available to assist the client with concerns the client may have with respect to the services provided by the arranged home care provider. The establishment shall keep each assisted living client reasonably informed of any changes in the personnel referenced in this subdivision. Upon request of the assisted living client, such personnel or designee shall provide reasonable assistance to the assisted living client in addressing concerns regarding services provided by the arranged home care provider.

Subd. 6. **Termination of housing with services contract.** If a housing with services establishment terminates a housing with services contract with an assisted living client, the establishment shall provide the assisted living client, and the legal or designated representative of

the assisted living client, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the section of the contract that authorizes the termination;

(3) without extending the termination notice period, an affirmative offer to meet with the assisted living client and, if applicable, client representatives, within no more than five business days of the date of the termination notice to discuss the termination;

(4) an explanation that:

(i) the assisted living client must vacate the apartment, along with all personal possessions, on or before the effective date of termination;

(ii) failure to vacate the apartment by the date of termination may result in the filing of an eviction action in court by the establishment, and that the assisted living client may present a defense, if any, to the court at that time; and

(iii) the assisted living client may seek legal counsel in connection with the notice of termination;

(5) a statement that, with respect to the notice of termination, reasonable accommodation is available for the disability of the assisted living client, if any; and

(6) the name and contact information of the representative of the establishment with whom the assisted living client or client representatives may discuss the notice of termination.

**144G.04 RESERVATION OF RIGHTS.**

Subdivision 1. **Use of services.** Nothing in this chapter requires an assisted living client to utilize any service provided or made available in assisted living.

Subd. 2. **Housing with services contracts.** Nothing in this chapter requires a housing with services establishment to execute or refrain from terminating a housing with services contract with a prospective or current resident who is unable or unwilling to meet the requirements of residency, with or without assistance.

Subd. 3. **Provision of services.** Nothing in this chapter requires the arranged home care provider to offer or continue to provide services under a service agreement or service plan to a prospective or current resident of the establishment whose needs cannot be met by the arranged home care provider.

Subd. 4. **Altering operations; service packages.** Nothing in this chapter requires a housing with services establishment or arranged home care provider offering assisted living to fundamentally alter the nature of the operations of the establishment or the provider in order to accommodate the request or need for facilities or services by any assisted living client, or to refrain from requiring, as a condition of residency, that an assisted living client pay for a package of assisted living services even if the client does not choose to utilize all or some of the services in the package.

**144G.05 REIMBURSEMENT UNDER ASSISTED LIVING SERVICE PACKAGES.**

Notwithstanding the provisions of this chapter, the requirements for the elderly waiver program's assisted living payment rates under section 256B.0915, subdivision 3e, shall continue to be effective and providers who do not meet the requirements of this chapter may continue to receive payment under section 256B.0915, subdivision 3e, as long as they continue to meet the definitions and standards for assisted living and assisted living plus set forth in the federally approved Elderly Home and Community Based Services Waiver Program (Control Number 0025.91). Providers of assisted living for the community access for disability inclusion (CADI) and Brain Injury (BI) waivers shall continue to receive payment as long as they continue to meet the definitions and standards for assisted living and assisted living plus set forth in the federally approved CADI and BI waiver plans.

**144G.06 UNIFORM CONSUMER INFORMATION GUIDE.**

The commissioner shall adopt a uniform format for the guide to be used by individual providers, and the required components of materials to be used by providers to inform assisted living clients of their legal rights, and shall make the uniform format and the required components available to assisted living providers.

**151.214 PAYMENT DISCLOSURE.**

Subd. 2. **No prohibition on disclosure.** No contracting agreement between an employer-sponsored health plan or health plan company, or its contracted pharmacy benefit manager, and a resident or nonresident pharmacy registered under this chapter, may prohibit the pharmacy from disclosing to patients information a pharmacy is required or given the option to provide under subdivision 1.

**151.42 CITATION.**

Sections 151.42 to 151.51 may be cited as the "Wholesale Drug Distribution Licensing Act of 1990."

**151.44 DEFINITIONS.**

As used in sections 151.43 to 151.51, the following terms have the meanings given in paragraphs (a) to (h):

(a) "Wholesale drug distribution" means distribution of prescription or nonprescription drugs to persons other than a consumer or patient or reverse distribution of such drugs, but does not include:

(1) a sale between a division, subsidiary, parent, affiliated, or related company under the common ownership and control of a corporate entity;

(2) the purchase or other acquisition, by a hospital or other health care entity that is a member of a group purchasing organization, of a drug for its own use from the organization or from other hospitals or health care entities that are members of such organizations;

(3) the sale, purchase, or trade of a drug or an offer to sell, purchase, or trade a drug by a charitable organization described in section 501(c)(3) of the Internal Revenue Code of 1986, as amended through December 31, 1988, to a nonprofit affiliate of the organization to the extent otherwise permitted by law;

(4) the sale, purchase, or trade of a drug or offer to sell, purchase, or trade a drug among hospitals or other health care entities that are under common control;

(5) the sale, purchase, or trade of a drug or offer to sell, purchase, or trade a drug for emergency medical reasons;

(6) the sale, purchase, or trade of a drug, an offer to sell, purchase, or trade a drug, or the dispensing of a drug pursuant to a prescription;

(7) the transfer of prescription or nonprescription drugs by a retail pharmacy to another retail pharmacy to alleviate a temporary shortage;

(8) the distribution of prescription or nonprescription drug samples by manufacturers representatives; or

(9) the sale, purchase, or trade of blood and blood components.

(b) "Wholesale drug distributor" means anyone engaged in wholesale drug distribution including, but not limited to, manufacturers; repackagers; own-label distributors; jobbers; brokers; warehouses, including manufacturers' and distributors' warehouses, chain drug warehouses, and wholesale drug warehouses; independent wholesale drug traders; and pharmacies that conduct wholesale drug distribution. A wholesale drug distributor does not include a common carrier or individual hired primarily to transport prescription or nonprescription drugs.

(c) "Manufacturer" has the meaning provided in section 151.01, subdivision 14a.

(d) "Prescription drug" means a drug required by federal or state law or regulation to be dispensed only by a prescription, including finished dosage forms and active ingredients subject to United States Code, title 21, sections 811 and 812.

(e) "Blood" means whole blood collected from a single donor and processed either for transfusion or further manufacturing.

(f) "Blood components" means that part of blood separated by physical or mechanical means.

(g) "Reverse distribution" means the receipt of prescription or nonprescription drugs received from or shipped to Minnesota locations for the purpose of returning the drugs to their producers or distributors.

(h) "Reverse distributor" means a person engaged in the reverse distribution of drugs.

**151.49 LICENSE RENEWAL APPLICATION PROCEDURES.**

Application blanks or notices for renewal of a license required by sections 151.42 to 151.51 shall be mailed or otherwise provided to each licensee on or before the first day of the month prior to the month in which the license expires and, if application for renewal of the license with the required fee and supporting documents is not made before the expiration date, the existing license or renewal shall lapse and become null and void upon the date of expiration.

**151.50 RULES.**

The board shall adopt rules to carry out the purposes and enforce the provisions of sections 151.42 to 151.51. All rules adopted under this section shall conform to wholesale drug distributor licensing guidelines formally adopted by the United States Food and Drug Administration; and in case of conflict between a rule adopted by the board and a Food and Drug Administration wholesale drug distributor guideline, the latter shall control.

**151.51 BOARD ACCESS TO WHOLESALE DRUG DISTRIBUTOR RECORDS.**

Wholesale drug distributors may keep records at a central location apart from the principal office of the wholesale drug distributor or the location at which the drugs were stored and from which they were shipped, provided that the records shall be made available for inspection within two working days of a request by the board. The records may be kept in any form permissible under federal law applicable to prescription drugs record keeping.

**151.55 CANCER DRUG REPOSITORY PROGRAM.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Board" means the Board of Pharmacy.

(c) "Cancer drug" means a prescription drug that is used to treat:

(1) cancer or the side effects of cancer; or

(2) the side effects of any prescription drug that is used to treat cancer or the side effects of cancer.

(d) "Cancer drug repository" means a medical facility or pharmacy that has notified the board of its election to participate in the cancer drug repository program.

(e) "Cancer supply" or "supplies" means prescription and nonprescription cancer supplies needed to administer a cancer drug.

(f) "Dispense" has the meaning given in section 151.01, subdivision 30.

(g) "Distribute" means to deliver, other than by administering or dispensing.

(h) "Donor" means an individual and not a drug manufacturer or wholesale drug distributor who donates a cancer drug or supply according to the requirements of the cancer drug repository program.

(i) "Medical facility" means an institution defined in section 144.50, subdivision 2.

(j) "Medical supplies" means any prescription and nonprescription medical supply needed to administer a cancer drug.

(k) "Pharmacist" has the meaning given in section 151.01, subdivision 3.

(l) "Pharmacy" means any pharmacy registered with the Board of Pharmacy according to section 151.19, subdivision 1.

(m) "Practitioner" has the meaning given in section 151.01, subdivision 23.

(n) "Prescription drug" means a legend drug as defined in section 151.01, subdivision 17.

(o) "Side effects of cancer" means symptoms of cancer.

(p) "Single-unit-dose packaging" means a single-unit container for articles intended for administration as a single dose, direct from the container.

(q) "Tamper-evident unit dose packaging" means a container within which a drug is sealed so that the contents cannot be opened without obvious destruction of the seal.

Subd. 2. **Establishment.** The Board of Pharmacy shall establish and maintain a cancer drug repository program, under which any person may donate a cancer drug or supply for use by an individual who meets the eligibility criteria specified under subdivision 4. Under the program, donations may be made on the premises of a medical facility or pharmacy that elects to participate in the program and meets the requirements specified under subdivision 3.

Subd. 3. **Requirements for participation by pharmacies and medical facilities.** (a) To be eligible for participation in the cancer drug repository program, a pharmacy or medical facility must be licensed and in compliance with all applicable federal and state laws and administrative rules.

(b) Participation in the cancer drug repository program is voluntary. A pharmacy or medical facility may elect to participate in the cancer drug repository program by submitting the following information to the board, in a form provided by the board:

(1) the name, street address, and telephone number of the pharmacy or medical facility;

(2) the name and telephone number of a pharmacist who is employed by or under contract with the pharmacy or medical facility, or other contact person who is familiar with the pharmacy's or medical facility's participation in the cancer drug repository program; and

(3) a statement indicating that the pharmacy or medical facility meets the eligibility requirements under paragraph (a) and the chosen level of participation under paragraph (c).

(c) A pharmacy or medical facility may fully participate in the cancer drug repository program by accepting, storing, and dispensing or administering donated drugs and supplies, or may limit its participation to only accepting and storing donated drugs and supplies. If a pharmacy or facility chooses to limit its participation, the pharmacy or facility shall distribute any donated drugs to a fully participating cancer drug repository according to subdivision 8.

(d) A pharmacy or medical facility may withdraw from participation in the cancer drug repository program at any time upon notification to the board. A notice to withdraw from participation may be given by telephone or regular mail.

Subd. 4. **Individual eligibility requirements.** Any Minnesota resident who is diagnosed with cancer is eligible to receive drugs or supplies under the cancer drug repository program. Drugs and supplies shall be dispensed or administered according to the priority given under subdivision 6, paragraph (d).

Subd. 5. **Donations of cancer drugs and supplies.** (a) Any one of the following persons may donate legally obtained cancer drugs or supplies to a cancer drug repository, if the drugs or supplies meet the requirements under paragraph (b) or (c) as determined by a pharmacist who is employed by or under contract with a cancer drug repository:

(1) an individual who is 18 years old or older; or

(2) a pharmacy, medical facility, drug manufacturer, or wholesale drug distributor, if the donated drugs have not been previously dispensed.

(b) A cancer drug is eligible for donation under the cancer drug repository program only if the following requirements are met:

(1) the donation is accompanied by a cancer drug repository donor form described under paragraph (d) that is signed by the person making the donation or that person's authorized representative;

(2) the drug's expiration date is at least six months later than the date that the drug was donated;

(3) the drug is in its original, unopened, tamper-evident unit dose packaging that includes the drug's lot number and expiration date. Single-unit dose drugs may be accepted if the single-unit-dose packaging is unopened; and

(4) the drug is not adulterated or misbranded.

(c) Cancer supplies are eligible for donation under the cancer drug repository program only if the following requirements are met:

(1) the supplies are not adulterated or misbranded;

(2) the supplies are in their original, unopened, sealed packaging; and

(3) the donation is accompanied by a cancer drug repository donor form described under paragraph (d) that is signed by the person making the donation or that person's authorized representative.

(d) The cancer drug repository donor form must be provided by the board and shall state that to the best of the donor's knowledge the donated drug or supply has been properly stored and that the drug or supply has never been opened, used, tampered with, adulterated, or misbranded. The board shall make the cancer drug repository donor form available on the Board of Pharmacy's website.

(e) Controlled substances and drugs and supplies that do not meet the criteria under this subdivision are not eligible for donation or acceptance under the cancer drug repository program.

(f) Drugs and supplies may be donated on the premises of a cancer drug repository to a pharmacist designated by the repository. A drop box may not be used to deliver or accept donations.

(g) Cancer drugs and supplies donated under the cancer drug repository program must be stored in a secure storage area under environmental conditions appropriate for the drugs or supplies being stored. Donated drugs and supplies may not be stored with nondonated inventory.

Subd. 6. **Dispensing requirements.** (a) Drugs and supplies must be dispensed by a licensed pharmacist pursuant to a prescription by a practitioner or may be dispensed or administered by a practitioner according to the requirements of this chapter and within the practitioner's scope of practice.

(b) Cancer drugs and supplies shall be visually inspected by the pharmacist or practitioner before being dispensed or administered for adulteration, misbranding, and date of expiration. Drugs or supplies that have expired or appear upon visual inspection to be adulterated, misbranded, or tampered with in any way may not be dispensed or administered.

(c) Before a cancer drug or supply may be dispensed or administered to an individual, the individual must sign a cancer drug repository recipient form provided by the board acknowledging that the individual understands the information stated on the form. The form shall include the following information:

(1) that the drug or supply being dispensed or administered has been donated and may have been previously dispensed;

(2) that a visual inspection has been conducted by the pharmacist or practitioner to ensure that the drug has not expired, has not been adulterated or misbranded, and is in its original, unopened packaging; and

(3) that the dispensing pharmacist, the dispensing or administering practitioner, the cancer drug repository, the Board of Pharmacy, and any other participant of the cancer drug repository program cannot guarantee the safety of the drug or supply being dispensed or administered and that the pharmacist or practitioner has determined that the drug or supply is safe to dispense or administer based on the accuracy of the donor's form submitted with the donated drug or supply and the visual inspection required to be performed by the pharmacist or practitioner before dispensing or administering.

The board shall make the cancer drug repository form available on the Board of Pharmacy's website.

(d) Drugs and supplies shall only be dispensed or administered to individuals who meet the eligibility requirements in subdivision 4 and in the following order of priority:

(1) individuals who are uninsured;

(2) individuals who are enrolled in medical assistance, MinnesotaCare, Medicare, or other public assistance health care; and

(3) all other individuals who are otherwise eligible under subdivision 4 to receive drugs or supplies from a cancer drug repository.

Subd. 7. **Handling fees.** A cancer drug repository may charge the individual receiving a drug or supply a handling fee of no more than 250 percent of the medical assistance program dispensing fee for each cancer drug or supply dispensed or administered.

Subd. 8. **Distribution of donated cancer drugs and supplies.** (a) Cancer drug repositories may distribute drugs and supplies donated under the cancer drug repository program to other repositories if requested by a participating repository.

(b) A cancer drug repository that has elected not to dispense donated drugs or supplies shall distribute any donated drugs and supplies to a participating repository upon request of the repository.

(c) If a cancer drug repository distributes drugs or supplies under paragraph (a) or (b), the repository shall complete a cancer drug repository donor form provided by the board. The completed form and a copy of the donor form that was completed by the original donor under subdivision 5 shall be provided to the fully participating cancer drug repository at the time of distribution.

Subd. 9. **Resale of donated drugs or supplies.** Donated drugs and supplies may not be resold.

Subd. 10. **Record-keeping requirements.** (a) Cancer drug repository donor and recipient forms shall be maintained for at least five years.

(b) A record of destruction of donated drugs and supplies that are not dispensed under subdivision 6 shall be maintained by the dispensing repository for at least five years. For each drug or supply destroyed, the record shall include the following information:

(1) the date of destruction;

(2) the name, strength, and quantity of the cancer drug destroyed;

(3) the name of the person or firm that destroyed the drug; and

(4) the source of the drugs or supplies destroyed.

Subd. 11. **Liability.** (a) The manufacturer of a drug or supply is not subject to criminal or civil liability for injury, death, or loss to a person or to property for causes of action described in clauses (1) and (2). A manufacturer is not liable for:

(1) the intentional or unintentional alteration of the drug or supply by a party not under the control of the manufacturer; or

(2) the failure of a party not under the control of the manufacturer to transfer or communicate product or consumer information or the expiration date of the donated drug or supply.

(b) A medical facility or pharmacy participating in the program, a pharmacist dispensing a drug or supply pursuant to the program, a practitioner dispensing or administering a drug or supply pursuant to the program, or a donor of a cancer drug or supply as defined in subdivision 1 is immune from civil liability for an act or omission that causes injury to or the death of an individual to whom the cancer drug or supply is dispensed and no disciplinary action shall be taken against a pharmacist or practitioner so long as the drug or supply is donated, accepted, distributed, and dispensed according to the requirements of this section. This immunity does not apply if the act or omission involves reckless, wanton, or intentional misconduct, or malpractice unrelated to the quality of the cancer drug or supply.

**151.60 PHARMACY AUDIT INTEGRITY PROGRAM.**

The pharmacy audit integrity program is established to provide standards for an audit of pharmacy records carried out by a pharmacy benefits manager or any entity that represents pharmacy benefits managers.

**151.61 DEFINITIONS.**

Subdivision 1. **Scope.** For the purposes of sections 151.60 to 151.70, the following terms have the meanings given.

Subd. 2. **Entity.** "Entity" means a pharmacy benefits manager or any person or organization that represents these companies, groups, or organizations.

Subd. 3. **Pharmacy benefits manager or PBM.** "Pharmacy benefits manager" or "PBM" means a person, business, or other entity that performs pharmacy benefits management. The term includes a person or entity acting for a PBM in a contractual or employment relationship in the performance of pharmacy benefits management.

Subd. 4. **Plan sponsor.** "Plan sponsor" means the employer in the case of an employee benefit plan established or maintained by a single employer, a group purchaser as defined in section 62J.03, subdivision 6, or the employee organization in the case of a plan established or maintained by an

employee organization, an association, joint board trustees, a committee, or other similar group that establishes or maintains the plan.

**151.62 PHARMACY BENEFIT MANAGER CONTRACT.**

An amendment to pharmacy audit terms in a contract between a PBM and a pharmacy must be disclosed to the pharmacy at least 60 days prior to the effective date of the proposed change.

**151.63 PROCEDURE AND PROCESS FOR CONDUCTING AND REPORTING AN AUDIT.**

Subdivision 1. **Audit procedures.** Unless otherwise prohibited by federal requirements or regulations, any entity conducting a pharmacy audit must follow the following procedures.

(1) A pharmacy must be given notice 14 days before an initial on-site audit is conducted.

(2) An audit that involves clinical or professional judgment must be conducted by or in consultation with a licensed pharmacist.

(3) Each pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies.

Subd. 2. **Audit process.** Unless otherwise prohibited by federal requirements or regulations, for any entity conducting a pharmacy audit the following audit items apply.

(1) The period covered by the audit may not exceed 24 months from the date that the claim was submitted to or adjudicated by the entity, unless a longer period is required under state or federal law.

(2) If an entity uses random sampling as a method for selecting a set of claims for examination, the sample size must be appropriate for a statistically reliable sample. Notwithstanding section 151.69, the auditing entity shall provide the pharmacy a masked list that provides a prescription number or date range that the auditing entity is seeking to audit.

(3) An on-site audit may not take place during the first five business days of the month unless consented to by the pharmacy.

(4) Auditors may not enter the pharmacy area unless escorted where patient-specific information is available and to the extent possible must be out of sight and hearing range of the pharmacy customers.

(5) Any recoupment will not be deducted against future remittances until after the appeals process and both parties have received the results of the final audit.

(6) A PBM may not require information to be written on a prescription unless the information is required to be written on the prescription by state or federal law. Recoupment may be assessed for items not written on the prescription if:

(i) additional information is required in the provider manual; or

(ii) the information is required by the Food and Drug Administration (FDA); or

(iii) the information is required by the drug manufacturer's product safety program; and

(iv) the information in clause (i), (ii), or (iii) is not readily available for the auditor at the time of the audit.

(7) The auditing company or agent may not receive payment based on a percentage of the amount recovered. This section does not prevent the entity conducting the audit from charging or assessing the responsible party, directly or indirectly, based on amounts recouped if both of the following conditions are met:

(i) the plan sponsor and the entity conducting the audit have a contract that explicitly states the percentage charge or assessment to the plan sponsor; and

(ii) a commission to an agent or employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped.

**151.64 REQUIREMENTS FOR RECOUPMENT OR CHARGEBACK.**

For recoupment or chargeback, the following criteria apply.

(1) Audit parameters must consider consumer-oriented parameters based on manufacturer listings.

(2) A pharmacy's usual and customary price for compounded medications is considered the reimbursable cost unless the pricing methodology is outlined in the provider contract.

(3) A finding of overpayment or underpayment must be based on the actual overpayment or underpayment and not a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs.

(4) The entity conducting the audit shall not use extrapolation in calculating the recoupment or penalties for audits unless required by state or federal law or regulations.

(5) Calculations of overpayments must not include dispensing fees unless a prescription was not actually dispensed, the prescriber denied authorization, the prescription dispensed was a medication error by the pharmacy, or the identified overpayment is solely based on an extra dispensing fee.

(6) An entity may not consider any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error regarding a required document or record as fraud, however such errors may be subject to recoupment.

(7) In the case of errors that have no actual financial harm to the patient or plan, the PBM must not assess any chargebacks. Errors that are a result of the pharmacy failing to comply with a formal corrective action plan may be subject to recovery.

(8) Interest may not accrue during the audit period for either party, beginning with the notice of the audit and ending with the final audit report.

**151.65 DOCUMENTATION.**

(a) To validate the pharmacy record and delivery, the pharmacy may use authentic and verifiable statements or records including medication administration records of a nursing home, assisted living facility, hospital, physician, or other authorized practitioner or additional audit documentation parameters located in the provider manual.

(b) Any legal prescription that meets the requirements in this chapter may be used to validate claims in connection with prescriptions, refills, or changes in prescriptions, including medication administration records, faxes, e-prescriptions, or documented telephone calls from the prescriber or the prescriber's agents.

**151.66 APPEALS PROCESS.**

The entity conducting the audit must establish a written appeals process which must include appeals of preliminary reports and final reports.

**151.67 AUDIT INFORMATION AND REPORTS.**

(a) A preliminary audit report must be delivered to the pharmacy within 60 days after the conclusion of the audit.

(b) A pharmacy must be allowed at least 45 days following receipt of the preliminary audit to provide documentation to address any discrepancy found in the audit.

(c) A final audit report must be delivered to the pharmacy within 120 days after receipt of the preliminary audit report or final appeal, whichever is later.

(d) An entity shall remit any money due to a pharmacy or pharmacist as a result of an underpayment of a claim within 45 days after the appeals process has been exhausted and the final audit report has been issued.

**151.68 DISCLOSURES TO PLAN SPONSOR.**

Where contractually required, an auditing entity must provide a copy to the plan sponsor of its claims that were included in the audit, and any recouped money shall be returned to the plan sponsor.

**151.69 APPLICABILITY OF OTHER LAWS AND REGULATIONS.**

Sections 151.62 to 151.67 do not apply to any investigative audit that involves suspected fraud, willful misrepresentation, abuse, or any audit completed by Minnesota health care programs.

**151.70 VIOLATIONS.**

Violations of sections 151.62 to 151.68 may be grounds for action, but are not deemed misdemeanors as described in section 151.29.

**151.71 MAXIMUM ALLOWABLE COST PRICING.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Health plan company" has the meaning provided in section 62Q.01, subdivision 4.

(c) "Pharmacy benefit manager" means an entity doing business in this state that contracts to administer or manage prescription drug benefits on behalf of any health plan company that provides prescription drug benefits to residents of this state.

Subd. 2. **Pharmacy benefit manager contracts with pharmacies; maximum allowable cost pricing.** (a) In each contract between a pharmacy benefit manager and a pharmacy, the pharmacy shall be given the right to obtain from the pharmacy benefit manager a current list of the sources used to determine maximum allowable cost pricing. The pharmacy benefit manager shall update the pricing information at least every seven business days and provide a means by which contracted pharmacies may promptly review current prices in an electronic, print, or telephonic format within one business day at no cost to the pharmacy. A pharmacy benefit manager shall maintain a procedure to eliminate products from the list of drugs subject to maximum allowable cost pricing in a timely manner in order to remain consistent with changes in the marketplace.

(b) In order to place a prescription drug on a maximum allowable cost list, a pharmacy benefit manager shall ensure that the drug is generally available for purchase by pharmacies in this state from a national or regional wholesaler and is not obsolete.

(c) Each contract between a pharmacy benefit manager and a pharmacy must include a process to appeal, investigate, and resolve disputes regarding maximum allowable cost pricing that includes:

(1) a 15-business day limit on the right to appeal following the initial claim;

(2) a requirement that the appeal be investigated and resolved within seven business days after the appeal is received; and

(3) a requirement that a pharmacy benefit manager provide a reason for any appeal denial and identify the national drug code of a drug that may be purchased by the pharmacy at a price at or below the maximum allowable cost price as determined by the pharmacy benefit manager.

(d) If an appeal is upheld, the pharmacy benefit manager shall make an adjustment to the maximum allowable cost price no later than one business day after the date of determination. The pharmacy benefit manager shall make the price adjustment applicable to all similarly situated network pharmacy providers as defined by the plan sponsor.

**214.17 HIV, HBV, AND HCV PREVENTION PROGRAM; PURPOSE AND SCOPE.**

Sections 214.17 to 214.25 are intended to promote the health and safety of patients and regulated persons by reducing the risk of infection in the provision of health care.

**214.18 DEFINITIONS.**

Subdivision 1. **Board.** "Board" means the Boards of Dentistry, Medical Practice, Nursing, and Podiatric Medicine. For purposes of sections 214.19, subdivisions 4 and 5; 214.20, paragraph (1); and 214.24, board also includes the Board of Chiropractic Examiners.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 3. **HBV.** "HBV" means the hepatitis B virus with the e antigen present in the most recent blood test.

Subd. 3a. **HCV.** "HCV" means the hepatitis C virus.

Subd. 4. **HIV.** "HIV" means the human immunodeficiency virus.

Subd. 5. **Regulated person.** "Regulated person" means a licensed dental hygienist, dentist, physician, nurse who is currently registered as a registered nurse or licensed practical nurse, podiatrist, a registered dental assistant, a physician assistant, and for purposes of sections 214.19, subdivisions 4 and 5; 214.20, paragraph (a); and 214.24, a chiropractor.

**214.19 REPORTING OBLIGATIONS.**

Subdivision 1. **Permission to report.** A person with actual knowledge that a regulated person has been diagnosed as infected with HIV, HBV, or HCV may file a report with the commissioner.

Subd. 2. **Self-reporting.** A regulated person who is diagnosed as infected with HIV, HBV, or HCV shall report that information to the commissioner promptly, and as soon as medically necessary for disease control purposes but no more than 30 days after learning of the diagnosis or 30 days after becoming licensed or registered by the state.

Subd. 3. **Mandatory reporting.** A person or institution required to report HIV, HBV, or HCV status to the commissioner under Minnesota Rules, parts 4605.7030, subparts 1 to 4 and 6, and 4605.7040, shall, at the same time, notify the commissioner if the person or institution knows that the reported person is a regulated person.

Subd. 4. **Infection control reporting.** A regulated person shall, within ten days, report to the appropriate board personal knowledge of a serious failure or a pattern of failure by another regulated person to comply with accepted and prevailing infection control procedures related to the prevention of HIV, HBV, and HCV transmission. In lieu of reporting to the board, the regulated person may make the report to a designated official of the hospital, nursing home, clinic, or other institution or agency where the failure to comply with accepted and prevailing infection control procedures occurred. The designated official shall report to the appropriate board within 30 days of receiving a report under this subdivision. The report shall include specific information about the response by the institution or agency to the report. A regulated person shall not be discharged or discriminated against for filing a complaint in good faith under this subdivision.

Subd. 5. **Immunity.** A person is immune from civil liability or criminal prosecution for submitting a report in good faith to the commissioner or to a board under this section.

**214.20 GROUNDS FOR DISCIPLINARY OR RESTRICTIVE ACTION.**

A board may refuse to grant a license or registration or may impose disciplinary or restrictive action against a regulated person who:

(1) fails to follow accepted and prevailing infection control procedures, including a failure to conform to current recommendations of the Centers for Disease Control for preventing the transmission of HIV, HBV, and HCV, or fails to comply with infection control rules promulgated by the board. Injury to a patient need not be established;

(2) fails to comply with any requirement of sections 214.17 to 214.24; or

(3) fails to comply with any monitoring or reporting requirement.

**214.21 TEMPORARY SUSPENSION.**

The board may, without hearing, temporarily suspend the right to practice of a regulated person if the board finds that the regulated person has refused to submit to or comply with monitoring under section 214.23. The suspension shall take effect upon written notice to the regulated person specifying the statute or rule violated. The suspension shall remain in effect until the board issues a final order based on a stipulation or after a hearing. At the time the board issues the suspension notice, the board shall schedule a disciplinary hearing to be held under chapter 14. The regulated person shall be provided with at least 20 days' notice of a hearing held under this section. The hearing shall be scheduled to begin no later than 30 days after the issuance of the suspension order.

**214.22 NOTICE; ACTION.**

If the board has reasonable grounds to believe a regulated person infected with HIV, HBV, or HCV has done or omitted doing any act that would be grounds for disciplinary action under section 214.20, the board may take action after giving notice three business days before the action, or a lesser time if deemed necessary by the board. The board may:

(1) temporarily suspend the regulated person's right to practice under section 214.21;

(2) require the regulated person to appear personally at a conference with representatives of the board and to provide information relating to the regulated person's health or professional practice; and

(3) take any other lesser action deemed necessary by the board for the protection of the public.

**214.23 MONITORING.**

Subdivision 1. **Commissioner of health.** The board shall enter into a contract with the commissioner to perform the functions in subdivisions 2 and 3. The contract shall provide that:

(1) unless requested to do otherwise by a regulated person, a board shall refer all regulated persons infected with HIV, HBV, or HCV to the commissioner;

(2) the commissioner may choose to refer any regulated person who is infected with HIV, HBV, or HCV as well as all information related thereto to the person's board at any time for any reason, including but not limited to: the degree of cooperation and compliance by the regulated person; the inability to secure information or the medical records of the regulated person; or when the facts may present other possible violations of the regulated persons practices act. Upon request of the regulated person who is infected with HIV, HBV, or HCV the commissioner shall refer the regulated person and all information related thereto to the person's board. Once the commissioner has referred a regulated person to a board, the board may not thereafter submit it to the commissioner to establish a monitoring plan unless the commissioner of health consents in writing;

(3) a board shall not take action on grounds relating solely to the HIV, HBV, or HCV status of a regulated person until after referral by the commissioner; and

(4) notwithstanding sections 13.39 and 13.41 and chapters 147, 147A, 148, 150A, 153, and 214, a board shall forward to the commissioner any information on a regulated person who is infected with HIV, HBV, or HCV that the Department of Health requests.

Subd. 2. **Monitoring plan.** After receiving a report that a regulated person is infected with HIV, HBV, or HCV, the board or the commissioner acting on behalf of the board shall evaluate the past and current professional practice of the regulated person to determine whether there has been a violation under section 214.20. After evaluation of the regulated person's past and current professional practice, the board or the commissioner, acting on behalf of the board, shall establish a monitoring plan for the regulated person. The monitoring plan may:

(1) address the scope of a regulated person's professional practice when the board or the commissioner, acting on behalf of the board, determines that the practice constitutes an identifiable risk of transmission of HIV, HBV, or HCV from the regulated person to the patient;

(2) include the submission of regular reports at a frequency determined by the board or the commissioner, acting on behalf of the board, regarding the regulated person's health status; and

(3) include any other provisions deemed reasonable by the board or the commissioner of health, acting on behalf of the board.

The board or commissioner, acting on behalf of the board, may enter into agreements with qualified persons to perform monitoring on its behalf. The regulated person shall comply with any monitoring plan established under this subdivision.

Subd. 3. **Expert review panel.** The board or the commissioner acting on behalf of the board may appoint an expert review panel to assist in the performance of the responsibilities under this section. In consultations with the expert review panel, the commissioner or board shall, to the extent possible, protect the identity of the regulated person. When an expert review panel is appointed, it must contain at least one member appointed by the commissioner and one professional member appointed by the board. The panel shall provide expert assistance to the board, or to the commissioner acting on behalf of the board, in the subjects of infectious diseases, epidemiology, practice techniques used by regulated persons, and other subjects determined by the board or by the commissioner acting on behalf of the board. Members of the expert review panel are subject to those provisions of chapter 13 that restrict the commissioner or the board under Laws 1992, chapter 559, article 1.

Subd. 4. **Immunity.** Members of the board or the commissioner acting on behalf of the board, and persons who participate on an expert review panel or who assist the board or the commissioner in monitoring the practice of a regulated person, are immune from civil liability or criminal prosecution for any actions, transactions, or publications made in good faith and in execution of, or relating to, their duties under sections 214.17 to 214.24, except that no immunity shall be available for persons who have knowingly violated any provision of chapter 13.

**214.24 INSPECTION OF PRACTICE.**

Subdivision 1. **Authority.** The board is authorized to conduct inspections of the clinical practice of a regulated person to determine whether the regulated person is following accepted and prevailing infection control procedures. The board shall provide at least three business days' notice to the clinical practice prior to the inspection. The clinical practice of a regulated person includes any location where the regulated person practices that is not an institution licensed and subject to inspection by the commissioner of health. During the course of inspections the privacy and confidentiality of patients and regulated persons shall be maintained. The board may require on license renewal forms that regulated persons inform the board of all locations where they practice.

Subd. 2. **Access; records.** An inspector from the board shall have access, during reasonable business hours for purposes of inspection, to all areas of the practice setting where patient care is rendered or drugs or instruments are held that come into contact with a patient. An inspector is authorized to interview employees and regulated persons in the performance of an inspection, to observe infection control procedures, test equipment used to sterilize instruments, and to review and copy all relevant records, excluding patient health records. In performing these responsibilities, inspectors shall make reasonable efforts to respect and preserve patient privacy and the privacy of the regulated person. Boards are authorized to conduct joint inspections and to share information obtained under this section. The boards shall contract with the commissioner to perform the duties under this subdivision.

Subd. 3. **Board action.** If accepted and prevailing infection control techniques are not being followed, the board may educate the regulated person or take other actions. The board and the inspector shall maintain patient confidentiality in any action resulting from the inspection.

Subd. 4. **Rulemaking.** A board is authorized to adopt rules setting standards for infection control procedures. Boards shall engage in joint rulemaking. Boards must seek and consider the advice of the commissioner of health before adopting rules. No inspections shall be conducted under this section until after infection control rules have been adopted. Each board is authorized to provide educational information and training to regulated persons regarding infection control. All regulated persons who are employers shall make infection control rules available to employees who engage in functions related to infection control.

**245.462 DEFINITIONS.**

Subd. 4a. **Clinical supervision.** "Clinical supervision" means the oversight responsibility for individual treatment plans and individual mental health service delivery, including that provided by the case manager. Clinical supervision must be accomplished by full or part-time employment of or contracts with mental health professionals. Clinical supervision must be documented by the mental health professional cosigning individual treatment plans and by entries in the client's record regarding supervisory activities.

**245E.06 ADMINISTRATIVE SANCTIONS.**

Subd. 2. **Written notice of department sanction; sanction effective date; informal meeting.** (a) The department shall give notice in writing to a person of an administrative sanction that is to be imposed. The notice shall be sent by mail as defined in section 245E.01, subdivision 11.

(b) The notice shall state:

(1) the factual basis for the department's determination;

(2) the sanction the department intends to take;

(3) the dollar amount of the monetary recovery or recoupment, if any;

(4) how the dollar amount was computed;

(5) the right to dispute the department's determination and to provide evidence;

(6) the right to appeal the department's proposed sanction; and

(7) the option to meet informally with department staff, and to bring additional documentation or information, to resolve the issues.

(c) In cases of determinations resulting in denial or termination of payments, in addition to the requirements of paragraph (b), the notice must state:

(1) the length of the denial or termination;

(2) the requirements and procedures for reinstatement; and

(3) the provider's right to submit documents and written arguments against the denial or termination of payments for review by the department before the effective date of denial or termination.

(d) The submission of documents and written argument for review by the department under paragraph (b), clause (5) or (7), or paragraph (c), clause (3), does not stay the deadline for filing an appeal.

(e) Notwithstanding section 245E.03, subdivision 4, the effective date of the proposed sanction shall be 30 days after the license holder's, provider's, controlling individual's, or recipient's receipt of the notice, unless timely appealed. If a timely appeal is made, the proposed sanction shall be delayed pending the final outcome of the appeal. Implementation of a proposed sanction following the resolution of a timely appeal may be postponed if, in the opinion of the department, the delay of sanction is necessary to protect the health or safety of children in care. The department may consider the economic hardship of a person in implementing the proposed sanction, but economic hardship shall not be a determinative factor in implementing the proposed sanction.

(f) Requests for an informal meeting to attempt to resolve issues and requests for appeals must be sent or delivered to the department's Office of Inspector General, Financial Fraud and Abuse Division.

Subd. 4. **Consolidated hearings with licensing sanction.** If a financial misconduct sanction has an appeal hearing right and it is timely appealed, and a licensing sanction exists for which there is an appeal hearing right and the sanction is timely appealed, and the overpayment recovery action and licensing sanction involve the same set of facts, the overpayment recovery action and licensing sanction must be consolidated in the contested case hearing related to the licensing sanction.

Subd. 5. **Effect of department's administrative determination or sanction.** Unless a timely and proper appeal is received by the department, the department's administrative determination or sanction shall be considered a final department determination.

**245H.10 BACKGROUND STUDIES.**

Subd. 2. **Direct contact.** (a) The subject of the background study may not provide direct contact services to a child served by a certified center unless the subject is under continuous direct supervision pending completion of the background study.

(b) The certified center must document in the staff person's personnel file the date the program initiates a background study and the date the subject of the study first had direct contact with a child served by the center.

**246.18 DISPOSAL OF FUNDS.**

Subd. 8. **State-operated services account.** (a) The state-operated services account is established in the special revenue fund. Revenue generated by new state-operated services listed under this section established after July 1, 2010, that are not enterprise activities must be deposited into the state-operated services account, unless otherwise specified in law:

(1) intensive residential treatment services;

(2) foster care services; and

(3) psychiatric extensive recovery treatment services.

(b) Funds deposited in the state-operated services account are appropriated to the commissioner of human services for the purposes of:

(1) providing services needed to transition individuals from institutional settings within state-operated services to the community when those services have no other adequate funding source; and

(2) funding the operation of the intensive residential treatment service program in Willmar.

Subd. 9. **Transfers.** The commissioner may transfer state mental health grant funds to the account in subdivision 8 for noncovered allowable costs of a provider certified and licensed under section 256B.0622 and operating under section 246.014.

**252.41 DEFINITIONS.**

Subd. 8. **Supported employment.** "Supported employment" means employment of a person with a disability so severe that the person needs ongoing training and support to get and keep a job in which:

(1) the person engages in paid work at a work site where individuals without disabilities who do not require public subsidies also may be employed;

(2) public funds are necessary to provide ongoing training and support services throughout the period of the person's employment; and

(3) the person has the opportunity for social interaction with individuals who do not have disabilities and who are not paid caregivers.

**252.431 SUPPORTED EMPLOYMENT SERVICES; DEPARTMENTAL DUTIES; COORDINATION.**

The commissioners of employment and economic development, human services, and education shall ensure that supported employment services provided as part of a comprehensive service system will:

(1) provide the necessary supports to assist persons with severe disabilities to obtain and maintain employment in normalized work settings available to the general work force that:

(i) maximize community and social integration; and

(ii) provide job opportunities that meet the individual's career potential and interests;

(2) allow persons with severe disabilities to actively participate in the planning and delivery of community-based employment services at the individual, local, and state level; and

(3) be coordinated among the Departments of Human Services, Employment and Economic Development, and Education to:

(i) promote the most efficient and effective funding;

(ii) avoid duplication of services; and

(iii) improve access and transition to employability services.

The commissioners of employment and economic development, human services, and education shall report to the legislature by January 1993 on the steps taken to implement this section.

**252.451 BUSINESS AGREEMENTS; SUPPORT AND SUPERVISION OF PERSONS WITH DISABILITIES.**

Subdivision 1. **Definition.** For the purposes of this section, "qualified business" means a business that employs primarily nondisabled persons and will employ persons with developmental disabilities. For purposes of this section, licensed providers of residential services for persons with developmental disabilities are not a qualified business. A qualified business and its employees are exempt from Minnesota Rules, parts 9525.1800 to 9525.1930.

Subd. 2. **Vendor participation and reimbursement.** Notwithstanding requirements in chapters 245A and 245D, and sections 252.28, 252.41 to 252.46, and 256B.501, vendors of day training and habilitation services may enter into written agreements with qualified businesses to provide additional training and supervision needed by individuals to maintain their employment.

Subd. 3. **Agreement specifications.** Agreements must include the following:

(1) the type and amount of supervision and support to be provided by the business to the individual in accordance with their needs as identified in their individual service plan;

(2) the methods used to periodically assess the individual's satisfaction with their work, training, and support;

(3) the measures taken by the qualified business and the vendor to ensure the health, safety, and protection of the individual during working hours, including the reporting of abuse and neglect under state law and rules;

(4) the training and support services the vendor will provide to the qualified business, including the frequency of on-site supervision and support; and

(5) any payment to be made to the qualified business by the vendor. Payment to the business must be limited to:

(i) additional costs of training coworkers and managers that exceed ordinary and customary training costs and are a direct result of employing a person with a developmental disability; and

(ii) additional costs for training, supervising, and assisting the person with a developmental disability that exceed normal and customary costs required for performing similar tasks or duties.

Payments made to a qualified business under this section must not include incentive payments to the qualified business or salary supplementation for the person with a developmental disability.

Subd. 4. **Client protection.** Persons receiving training and support under this section may not be denied their rights or procedural protections under section 256.045, subdivision 4a, or 256B.092, including the county agency's responsibility to arrange for appropriate services, as necessary, in the event that persons lose their job or the contract with the qualified business is terminated.

Subd. 5. **Vendor payment.** (a) For purposes of this section, the vendor shall bill and the commissioner shall reimburse the vendor for full-day or partial-day services to a client that would otherwise have been paid to the vendor for providing direct services, provided that both of the following criteria are met:

(1) the vendor provides services and payments to the qualified business that enable the business to perform support and supervision services for the client that the vendor would otherwise need to perform; and

(2) the client for whom a rate will be billed will receive full-day or partial-day services from the vendor and the rate to be paid the vendor will allow the client to work with this support and supervision at the qualified business instead of receiving these services from the vendor.

(b) Medical assistance reimbursement of services provided to persons receiving day training and habilitation services under this section is subject to the limitations on reimbursement for vocational services under federal law and regulation.

**254B.03 RESPONSIBILITY TO PROVIDE CHEMICAL DEPENDENCY TREATMENT.**

Subd. 4a. **Division of costs for medical assistance services.** Notwithstanding subdivision 4, for chemical dependency services provided on or after October 1, 2008, and reimbursed by medical assistance, the county share is 30 percent of the nonfederal share.

**256B.0615 MENTAL HEALTH CERTIFIED PEER SPECIALIST.**

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified peer specialist program model, which:

(1) provides nonclinical peer support counseling by certified peer specialists;

(2) provides a part of a wraparound continuum of services in conjunction with other community mental health services;

(3) is individualized to the consumer; and

(4) promotes socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

Subd. 4. **Peer support specialist program providers.** The commissioner shall develop a process to certify peer support specialist programs, in accordance with the federal guidelines, in order for the program to bill for reimbursable services. Peer support programs may be freestanding or within existing mental health community provider centers.

Subd. 5. **Certified peer specialist training and certification.** The commissioner of human services shall develop a training and certification process for certified peer specialists, who must be at least 21 years of age. The candidates must have had a primary diagnosis of mental illness, be a current or former consumer of mental health services, and must demonstrate leadership and advocacy skills and a strong dedication to recovery. The training curriculum must teach participating consumers specific skills relevant to providing peer support to other consumers. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to peer support counseling.

**256B.0616 MENTAL HEALTH CERTIFIED FAMILY PEER SPECIALIST.**

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified family peer specialists program model which:

(1) provides nonclinical family peer support counseling, building on the strengths of families and helping them achieve desired outcomes;

(2) collaborates with others providing care or support to the family;

(3) provides nonadversarial advocacy;

(4) promotes the individual family culture in the treatment milieu;

(5) links parents to other parents in the community;

(6) offers support and encouragement;

(7) assists parents in developing coping mechanisms and problem-solving skills;

(8) promotes resiliency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services;

(9) establishes and provides peer-led parent support groups; and

(10) increases the child's ability to function better within the child's home, school, and community by educating parents on community resources, assisting with problem solving, and educating parents on mental illnesses.

Subd. 4. **Peer support specialist program providers.** The commissioner shall develop a process to certify family peer support specialist programs, in accordance with the federal guidelines, in order for the program to bill for reimbursable services. Family peer support programs must operate within an existing mental health community provider or center.

Subd. 5. **Certified family peer specialist training and certification.** The commissioner shall develop a training and certification process for certified family peer specialists who must be at least 21 years of age. The candidates must have raised or be currently raising a child with a mental illness, have had experience navigating the children's mental health system, and must demonstrate leadership and advocacy skills and a strong dedication to family-driven and family-focused services. The training curriculum must teach participating family peer specialists specific skills relevant to providing peer support to other parents. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to family peer support counseling.

**256B.0624 ADULT CRISIS RESPONSE SERVICES COVERED.**

Subd. 10. **Recipient file.** Providers of mobile crisis intervention or crisis stabilization services must maintain a file for each recipient containing the following information:

(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;

(2) signed release forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

(5) case records which document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;

(6) required clinical supervision by mental health professionals;

(7) summary of the recipient's case reviews by staff;

(8) any written information by the recipient that the recipient wants in the file; and

(9) an advance directive, if there is one available.

Documentation in the file must comply with all requirements of the commissioner.

**256B.0625 COVERED SERVICES.**

Subd. 63. **Payment for multiple services provided on the same day.** The commissioner shall not prohibit payment, including supplemental payments, for mental health services or dental services provided to a patient by a clinic or health care professional solely because the mental health or dental services were provided on the same day as other covered health services furnished by the same provider.

**256B.0659 PERSONAL CARE ASSISTANCE PROGRAM.**

Subd. 22. **Annual review for personal care providers.** (a) All personal care assistance provider agencies shall resubmit, on an annual basis, the information specified in subdivision 21, in a format determined by the commissioner, and provide a copy of the personal care assistance provider agency's most current version of its grievance policies and procedures along with a written record

of grievances and resolutions of the grievances that the personal care assistance provider agency has received in the previous year and any other information requested by the commissioner.

(b) The commissioner shall send annual review notification to personal care assistance provider agencies 30 days prior to renewal. The notification must:

(1) list the materials and information the personal care assistance provider agency is required to submit;

(2) provide instructions on submitting information to the commissioner; and

(3) provide a due date by which the commissioner must receive the requested information.

Personal care assistance provider agencies shall submit required documentation for annual review within 30 days of notification from the commissioner. If no documentation is submitted, the personal care assistance provider agency enrollment number must be terminated or suspended.

(c) Personal care assistance provider agencies also currently licensed under section 144A.471, subdivision 6 or 7, or currently certified for participation in Medicare as a home health agency are deemed in compliance with the personal care assistance requirements for enrollment, annual review process, and documentation.

**256B.0705 PERSONAL CARE ASSISTANCE SERVICES; MANDATED SERVICE VERIFICATION.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "Personal care assistance services" or "PCA services" means services provided according to section 256B.0659.

(c) "Personal care assistant" or "PCA" has the meaning given in section 256B.0659, subdivision 1.

(d) "Service verification" means a random, unscheduled telephone call made for the purpose of verifying that the individual personal care assistant is present at the location where personal care assistance services are being provided and is providing services as scheduled.

Subd. 2. **Verification schedule.** An agency that submits claims for reimbursement for PCA services under this chapter must develop and implement administrative policies and procedures by which the agency verifies the services provided by a PCA. For each service recipient, the agency must conduct at least one service verification every 90 days. If more than one PCA provides services to a single service recipient, the agency must conduct a service verification for each PCA providing services before conducting a service verification for a PCA whose services were previously verified by the agency. Service verification must occur on an ongoing basis while the agency provides PCA services to the recipient. During service verification, the agency must speak with both the PCA and the service recipient or recipient's authorized representative. Only qualified professional service verifications are eligible for reimbursement. An agency may substitute a visit by a qualified professional that is eligible for reimbursement under section 256B.0659, subdivision 14 or 19.

Subd. 3. **Documentation of verification.** An agency must fully document service verifications in a legible manner and must maintain the documentation on site for at least five years from the date of documentation. For each service verification, documentation must include:

(1) the names and signatures of the service recipient or recipient's authorized representative, the PCA and any other agency staff present with the PCA during the service verification, and the staff person conducting the service verification; and

(2) the start and end time, day, month, and year of the service verification, and the corresponding PCA time sheet.

Subd. 4. **Variance.** The Office of Inspector General at the Department of Human Services may grant a variance to the service verification requirements in this section if an agency uses an electronic monitoring system or other methods that verify a PCA is present at the location where services are provided and is providing services according to the prescribed schedule. A decision to grant or deny a variance request is final and not subject to appeal under chapter 14.

**256B.0943 CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.**

Subd. 10. **Service authorization.** Children's therapeutic services and supports are subject to authorization criteria and standards published by the commissioner according to section 256B.0625, subdivision 25.

**256B.0944 CHILDREN'S MENTAL HEALTH CRISIS RESPONSE SERVICES.**

Subd. 10. **Client record.** The provider must maintain a file for each client that complies with the requirements under section 256B.0943, subdivision 11, and contains the following information:

(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient for not signing the plan;

(2) signed release of information forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

(5) case records that document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;

(6) required clinical supervision by mental health professionals;

(7) summary of the recipient's case reviews by staff; and

(8) any written information by the recipient that the recipient wants in the file.

**256B.0946 INTENSIVE TREATMENT IN FOSTER CARE.**

Subd. 5. **Service authorization.** The commissioner will administer authorizations for services under this section in compliance with section 256B.0625, subdivision 25.

**256B.0947 INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES.**

Subd. 9. **Service authorization.** The commissioner shall publish prior authorization criteria and standards to be used for intensive nonresidential rehabilitative mental health services, as provided in section 256B.0625, subdivision 25.

**256B.431 RATE DETERMINATION.**

Subd. 3a. **Property-related costs after July 1, 1985.** (a) For rate years beginning on or after July 1, 1985, the commissioner, by permanent rule, shall reimburse nursing facility providers that are vendors in the medical assistance program for the rental use of real estate and depreciable equipment. "Real estate" means land improvements, buildings, and attached fixtures used directly for resident care. "Depreciable equipment" means the standard movable resident care equipment and support service equipment generally used in long-term care facilities.

(b) In developing the method for determining payment rates for the rental use of nursing facilities, the commissioner shall consider factors designed to:

(1) simplify the administrative procedures for determining payment rates for property-related costs;

(2) minimize discretionary or appealable decisions;

(3) eliminate any incentives to sell nursing facilities;

(4) recognize legitimate costs of preserving and replacing property;

(5) recognize the existing costs of outstanding indebtedness allowable under the statutes and rules in effect on May 1, 1983;

(6) address the current value of, if used directly for patient care, land improvements, buildings, attached fixtures, and equipment;

(7) establish an investment per bed limitation;

(8) reward efficient management of capital assets;

(9) provide equitable treatment of facilities;

(10) consider a variable rate; and

(11) phase-in implementation of the rental reimbursement method.

(c) For rate years beginning on or after July 1, 1987, a nursing facility which has reduced licensed bed capacity after January 1, 1986, shall be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed prior to the reduction; and

(2) establish capacity days for each rate year following the licensure reduction based on the number of beds licensed on the previous April 1 if the commissioner is notified of the change by April 4. The notification must include a copy of the delicensure request that has been submitted to the commissioner of health.

(d) For rate years beginning on or after July 1, 1989, the interest expense that results from a refinancing of a nursing facility's demand call loan, when the loan that must be refinanced was incurred before May 22, 1983, is an allowable interest expense if:

(1) the demand call loan or any part of it was in the form of a loan that was callable at the demand of the lender;

(2) the demand call loan or any part of it was called by the lender through no fault of the nursing facility;

(3) the demand call loan or any part of it was made by a government agency operating under a statutory or regulatory loan program;

(4) the refinanced debt does not exceed the sum of the allowable remaining balance of the demand call loan at the time of payment on the demand call loan and refinancing costs;

(5) the term of the refinanced debt does not exceed the remaining term of the demand call loan, had the debt not been subject to an on-call payment demand; and

(6) the refinanced debt is not a debt between related organizations as defined in Minnesota Rules, part 9549.0020, subpart 38.

Subd. 3f. **Property costs after July 1, 1988.** (a) For the rate year beginning July 1, 1988, the replacement-cost-new per bed limit must be $32,571 per licensed bed in multiple bedrooms and $48,857 per licensed bed in a single bedroom. For the rate year beginning July 1, 1989, the replacement-cost-new per bed limit for a single bedroom must be $49,907 adjusted according to Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1990, the replacement-cost-new per bed limits must be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1991, the replacement-cost-new per bed limits will be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1), except that the index utilized will be the Bureau of Economic Analysis: Price Indexes for Private Fixed Investments in Structures; Special Care.

(b) For the rate year beginning July 1, 1988, the commissioner shall increase the rental factor as established in Minnesota Rules, part 9549.0060, subpart 8, item A, by 6.2 percent rounded to the nearest 100th percent for the purpose of reimbursing nursing facilities for soft costs and entrepreneurial profits not included in the cost valuation services used by the state's contracted appraisers. For rate years beginning on or after July 1, 1989, the rental factor is the amount determined under this paragraph for the rate year beginning July 1, 1988.

(c) For rate years beginning on or after July 1, 1988, in order to determine property-related payment rates under Minnesota Rules, part 9549.0060, for all nursing facilities except those whose average length of stay in a skilled level of care within a nursing facility is 180 days or less, the commissioner shall use 95 percent of capacity days. For a nursing facility whose average length of stay in a skilled level of care within a nursing facility is 180 days or less, the commissioner shall use the greater of resident days or 80 percent of capacity days but in no event shall the divisor exceed 95 percent of capacity days.

(d) For rate years beginning on July 1, 1988, and July 1, 1989, the commissioner shall add ten cents per resident per day to each nursing facility's property-related payment rate. The ten-cent property-related payment rate increase is not cumulative from rate year to rate year. For the rate year beginning July 1, 1990, the commissioner shall increase each nursing facility's equipment allowance as established in Minnesota Rules, part 9549.0060, subpart 10, by ten cents per resident per day. For rate years beginning on or after July 1, 1991, the adjusted equipment allowance must

be adjusted annually for inflation as in Minnesota Rules, part 9549.0060, subpart 10, item E. For the rate period beginning October 1, 1992, the equipment allowance for each nursing facility shall be increased by 28 percent. For rate years beginning after June 30, 1993, the allowance must be adjusted annually for inflation.

(e) For rate years beginning on or after July 1, 1990, Minnesota Rules, part 9549.0060, subpart 5, item E, shall not apply to outstanding related organization debt incurred prior to May 23, 1983, provided that the debt was an allowable debt under Minnesota Rules, parts 9510.0010 to 9510.0480, the debt is subject to repayment through annual principal payments, and the nursing facility demonstrates to the commissioner's satisfaction that the interest rate on the debt was less than market interest rates for similar arm's-length transactions at the time the debt was incurred. If the debt was incurred due to a sale between family members, the nursing facility must also demonstrate that the seller no longer participates in the management or operation of the nursing facility. Debts meeting the conditions of this paragraph are subject to all other provisions of Minnesota Rules, parts 9549.0010 to 9549.0080.

(f) For rate years beginning on or after July 1, 1990, a nursing facility with operating lease costs incurred for the nursing facility's buildings shall receive its building capital allowance computed in accordance with Minnesota Rules, part 9549.0060, subpart 8. If an operating lease provides that the lessee's rent is adjusted to recognize improvements made by the lessor and related debt, the costs for capital improvements and related debt shall be allowed in the computation of the lessee's building capital allowance, provided that reimbursement for these costs under an operating lease shall not exceed the rate otherwise paid.

Subd. 3g. **Property costs after July 1, 1990, for certain facilities.** (a) For rate years beginning on or after July 1, 1990, nursing facilities that, on or after January 1, 1976, but prior to January 1, 1987, were newly licensed after new construction, or increased their licensed beds by a minimum of 35 percent through new construction, and whose building capital allowance is less than their allowable annual principal and interest on allowable debt prior to the application of the replacement-cost-new per bed limit and whose remaining weighted average debt amortization schedule as of January 1, 1988, exceeded 15 years, must receive a property-related payment rate equal to the greater of their rental per diem or their annual allowable principal and allowable interest without application of the replacement-cost-new per bed limit, divided by their capacity days as determined under Minnesota Rules, part 9549.0060, subpart 11, as modified by subdivision 3f, paragraph (c), for the preceding reporting year, plus their equipment allowance. A nursing facility that is eligible for a property-related payment rate under this subdivision and whose property-related payment rate in a subsequent rate year is its rental per diem must continue to have its property-related payment rates established for all future rate years based on the rental reimbursement method in Minnesota Rules, part 9549.0060.

The commissioner may require the nursing facility to apply for refinancing as a condition of receiving special rate treatment under this subdivision.

(b) If a nursing facility is eligible for a property-related payment rate under this subdivision, and the nursing facility's debt is refinanced after October 1, 1988, the provisions in paragraphs (1) to (7) also apply to the property-related payment rate for rate years beginning on or after July 1, 1990.

(1) A nursing facility's refinancing must not include debts with balloon payments.

(2) If the issuance costs, including issuance costs on the debt refinanced, are financed as part of the refinancing, the historical cost of capital assets limit in Minnesota Rules, part 9549.0060, subpart 5, item A, subitem (6), includes issuance costs that do not exceed seven percent of the debt refinanced, plus the related issuance costs. For purposes of this paragraph, issuance costs means the fees charged by the underwriter, issuer, attorneys, bond raters, appraisers, and trustees, and includes the cost of printing, title insurance, registration tax, and a feasibility study for the refinancing of a nursing facility's debt. Issuance costs do not include bond premiums or discounts when bonds are sold at other than their par value, points, or a bond reserve fund. To the extent otherwise allowed under this paragraph, the straight-line amortization of the refinancing issuance costs is not an allowable cost.

(3) The annual principal and interest expense payments and any required annual municipal fees on the nursing facility's refinancing replace those of the refinanced debt and, together with annual principal and interest payments on other allowable debts, are allowable costs subject to the limitation on historical cost of capital assets plus issuance costs as limited in paragraph (2), if any.

(4) If the nursing facility's refinancing includes zero coupon bonds, the commissioner shall establish a monthly debt service payment schedule based on an annuity that will produce an amount equal to the zero coupon bonds at maturity. The term and interest rate is the term and interest rate of the zero coupon bonds. Any refinancing to repay the zero coupon bonds is not an allowable cost.

(5) The annual amount of annuity payments is added to the nursing facility's allowable annual principal and interest payment computed in paragraph (3).

(6) The property-related payment rate is equal to the amount in paragraph (5), divided by the nursing facility's capacity days as determined under Minnesota Rules, part 9549.0060, subpart 11, as modified by subdivision 3f, paragraph (c), for the preceding reporting year plus an equipment allowance.

(7) Except as provided in this subdivision, the provisions of Minnesota Rules, part 9549.0060 apply.

Subd. 3i. **Property costs for the rate year beginning July 1, 1990.** Notwithstanding Minnesota Rules, part 9549.0060, subpart 13, item H, the commissioner shall determine property-related payment rates for nursing facilities for the rate year beginning July 1, 1990, as follows:

(a) The property-related payment rate for a nursing facility that qualifies under subdivision 3g is the greater of the rate determined under that subdivision or the rate determined under paragraph (c), (d), or (e), whichever is applicable.

(b) Nursing facilities shall be grouped according to the type of property-related payment rate the commissioner determined for the rate year beginning July 1, 1989. A nursing facility whose property-related payment rate was determined under Minnesota Rules, part 9549.0060, subpart 13, item A (full rental reimbursement), shall be considered group A. A nursing facility whose property-related payment rate was determined under Minnesota Rules, part 9549.0060, subpart 13, item B (phase-down to full rental reimbursement), shall be considered group B. A nursing facility whose property-related payment rate was determined under Minnesota Rules, part 9549.0060, subpart 13, item C or D (phase-up to full rental reimbursement), shall be considered group C.

(c) For the rate year beginning July 1, 1990, a group A nursing facility shall receive its property-related payment rate determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(d) For the rate year beginning July 1, 1990, a Group B nursing facility shall receive the greater of 87 percent of the property-related payment rate in effect on July 1, 1989; or the rental per diem rate determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section in effect on July 1, 1990; or the sum of 100 percent of the nursing facility's allowable principal and interest expense, plus its equipment allowance multiplied by the resident days for the reporting year ending September 30, 1989, divided by the nursing facility's capacity days as determined under Minnesota Rules, part 9549.0060, subpart 11, as modified by subdivision 3f, paragraph (c); except that the nursing facility's property-related payment rate must not exceed its property-related payment rate in effect on July 1, 1989.

(e) For the rate year beginning July 1, 1990, a group C nursing facility shall receive its property-related payment rate determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, except the rate must not exceed the lesser of its property-related payment rate determined for the rate year beginning July 1, 1989, multiplied by 116 percent or its rental per diem rate determined effective July 1, 1990.

(f) The property-related payment rate for a nursing facility that qualifies for a rate adjustment under Minnesota Rules, part 9549.0060, subpart 13, item G (special reappraisals), shall have the property-related payment rate determined in paragraphs (a) to (e) adjusted according to the provisions in that rule.

(g) Except as provided in subdivision 4, paragraph (f), and subdivision 11, a nursing facility that has a change in ownership or a reorganization of provider entity is subject to the provisions of Minnesota Rules, part 9549.0060, subpart 13, item F.

Subd. 10. **Property rate adjustments and construction projects.** A nursing facility completing a construction project that is eligible for a rate adjustment under section 256B.434, subdivision 4f, and that was not approved through the moratorium exception process in section 144A.073 must request from the commissioner a property-related payment rate adjustment. The effective date of the rate adjustment is the first of the month of January or July, whichever occurs first following both the construction project's completion date and submission of the provider's rate adjustment

request. The commissioner shall provide a rate notice reflecting the allowable costs within 60 days after receiving all the necessary information to compute the rate adjustment. No sooner than the effective date of the rate adjustment for the construction project, a nursing facility may adjust its rates by the amount anticipated to be allowed. Any amounts collected from private pay residents in excess of the allowable rate must be repaid to private pay residents with interest at the rate used by the commissioner of revenue for the late payment of taxes and in effect on the date the rate increase is effective. Construction projects with completion dates within one year of the completion date associated with the property rate adjustment request and phased projects with project completion dates within three years of the last phase of the phased project must be aggregated for purposes of the minimum thresholds in subdivisions 16 and 17, and the maximum threshold in section 144A.071, subdivision 2. "Construction project" and "project construction costs" have the meanings given them in section 144A.071, subdivision 1a.

Subd. 13. **Hold-harmless property-related rates.** (a) Terms used in subdivisions 13 to 21 shall be as defined in Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(b) Except as provided in this subdivision, for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the property-related rate for a nursing facility shall be the greater of $4 or the property-related payment rate in effect on September 30, 1992. In addition, the incremental increase in the nursing facility's rental rate will be determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(c) Notwithstanding Minnesota Rules, part 9549.0060, subpart 13, item F, a nursing facility that has a sale permitted under subdivision 14 after June 30, 1992, shall receive the property-related payment rate in effect at the time of the sale or reorganization. For rate periods beginning after October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility shall receive, in addition to its property-related payment rate in effect at the time of the sale, the incremental increase allowed under subdivision 14.

(d) For rate years beginning after June 30, 1993, the property-related rate for a nursing facility licensed after July 1, 1989, after relocating its beds from a separate nursing home to a building formerly used as a hospital and sold during the cost reporting year ending September 30, 1991, shall be its property-related rate prior to the sale in addition to the incremental increases provided under this section effective on October 1, 1992, of 29 cents per day, and any incremental increases after October 1, 1992, calculated by using its rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, recognizing the current appraised value of the facility at the new location, and including as allowable debt otherwise allowable debt incurred to remodel the facility in the new location prior to the relocation of beds.

Subd. 15. **Capital repair and replacement cost reporting and rate calculation.** For rate years beginning after June 30, 1993, a nursing facility's capital repair and replacement payment rate shall be established annually as provided in paragraphs (a) to (e).

(a) Notwithstanding Minnesota Rules, part 9549.0060, subpart 12, the costs of any of the following items not included in the equity incentive computations under subdivision 16 or reported as a capital asset addition under subdivision 18, paragraph (b), including cash payment for equity investment and principal and interest expense for debt financing, must be reported in the capital repair and replacement cost category:

(1) wall coverings;

(2) paint;

(3) floor coverings;

(4) window coverings;

(5) roof repair; and

(6) window repair or replacement.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subpart 12, the repair or replacement of a capital asset not included in the equity incentive computations under subdivision 16 or reported as a capital asset addition under subdivision 18, paragraph (b), must be reported under this subdivision when the cost of the item exceeds $500, or in the plant operations and maintenance cost category when the cost of the item is equal to or less than $500.

(c) To compute the capital repair and replacement payment rate, the allowable annual repair and replacement costs for the reporting year must be divided by actual resident days for the reporting

year. The annual allowable capital repair and replacement costs shall not exceed $150 per licensed bed. The excess of the allowed capital repair and replacement costs over the capital repair and replacement limit shall be a cost carryover to succeeding cost reporting periods, except that sale of a facility, under subdivision 14, shall terminate the carryover of all costs except those incurred in the most recent cost reporting year. The termination of the carryover shall have effect on the capital repair and replacement rate on the same date as provided in subdivision 14, paragraph (f), for the sale. For rate years beginning after June 30, 1994, the capital repair and replacement limit shall be subject to the index provided in subdivision 3f, paragraph (a). For purposes of this subdivision, the number of licensed beds shall be the number used to calculate the nursing facility's capacity days. The capital repair and replacement rate must be added to the nursing facility's total payment rate.

(d) Capital repair and replacement costs under this subdivision shall not be counted as either care-related or other operating costs, nor subject to care-related or other operating limits.

(e) If costs otherwise allowable under this subdivision are incurred as the result of a project approved under the moratorium exception process in section 144A.073, or in connection with an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost of these assets exceeds the lesser of $150,000 or ten percent of the nursing facility's appraised value, these costs must be claimed under subdivision 16 or 17, as appropriate.

Subd. 16. **Major additions and replacements; equity incentive.** For rate years beginning after June 30, 1993, if a nursing facility acquires capital assets in connection with a project approved under the moratorium exception process in section 144A.073 or in connection with an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost of those capital asset additions exceeds the lesser of $150,000 or ten percent of the most recent appraised value, the nursing facility shall be eligible for an equity incentive payment rate as in paragraphs (a) to (d). This computation is separate from the determination of the nursing facility's rental rate. An equity incentive payment rate as computed under this subdivision is limited to one in a 12-month period.

(a) An eligible nursing facility shall receive an equity incentive payment rate equal to the allowable historical cost of the capital asset acquired, minus the allowable debt directly identified to that capital asset, multiplied by the equity incentive factor as described in paragraphs (b) and (c), and divided by the nursing facility's occupancy factor under subdivision 3f, paragraph (c). This amount shall be added to the nursing facility's total payment rate and shall be effective the same day as the incremental increase in paragraph (d) or subdivision 17. The allowable historical cost of the capital assets and the allowable debt shall be determined as provided in Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(b) The equity incentive factor shall be determined under clauses (1) to (4):

(1) divide the initial allowable debt in paragraph (a) by the initial historical cost of the capital asset additions referred to in paragraph (a), then cube the quotient,

(2) subtract the amount calculated in clause (1) from the number one,

(3) determine the difference between the rental factor and the lesser of two percentage points above the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation as published in the Wall Street Journal and in effect on the first day of the month the debt or cost is incurred, or 16 percent,

(4) multiply the amount calculated in clause (2) by the amount calculated in clause (3).

(c) The equity incentive payment rate shall be limited to the term of the allowable debt in paragraph (a), not greater than 20 years nor less than ten years. If no debt is incurred in acquiring the capital asset, the equity incentive payment rate shall be paid for ten years. The sale of a nursing facility under subdivision 14 shall terminate application of the equity incentive payment rate effective on the date provided in subdivision 14, paragraph (f), for the sale.

(d) A nursing facility with an addition to or a renovation of its buildings, attached fixtures, or land improvements meeting the criteria in this subdivision and not receiving the property-related payment rate adjustment in subdivision 17, shall receive the incremental increase in the nursing facility's rental rate as determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section. The incremental increase shall be added to the nursing facility's property-related payment rate. The effective date of this incremental increase shall be the first day of the month of January or July, whichever occurs first following the date on which the addition or replacement is completed.

Subd. 17. **Special provisions for moratorium exceptions.** Notwithstanding Minnesota Rules, part 9549.0060, subpart 3, for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility that (1) has completed a construction project approved under section 144A.071, subdivision 4a, clause (m); (2) has completed a construction project approved under section 144A.071, subdivision 4a, and effective after June 30, 1995; (3) has completed a construction project approved under section 144A.071, subdivision 4c; or (4) has completed a renovation, replacement, or upgrading project approved under the moratorium exception process in section 144A.073 shall be reimbursed for costs directly identified to that project as provided in subdivision 16 and subdivisions 17 to 17f.

Subd. 17a. **Allowable interest expense.** (a) Notwithstanding Minnesota Rules, part 9549.0060, subparts 5, item A, subitems (1) and (3), and 7, item D, allowable interest expense on debt shall include:

(1) interest expense on debt related to the cost of purchasing or replacing depreciable equipment, excluding vehicles, not to exceed ten percent of the total historical cost of the project; and

(2) interest expense on debt related to financing or refinancing costs, including costs related to points, loan origination fees, financing charges, legal fees, and title searches; and issuance costs including bond discounts, bond counsel, underwriter's counsel, corporate counsel, printing, and financial forecasts. Allowable debt related to items in this clause shall not exceed seven percent of the total historical cost of the project. To the extent these costs are financed, the straight-line amortization of the costs in this clause is not an allowable cost; and

(3) interest on debt incurred for the establishment of a debt reserve fund, net of the interest earned on the debt reserve fund.

(b) Debt incurred for costs under paragraph (a) is not subject to Minnesota Rules, part 9549.0060, subpart 5, item A, subitem (5) or (6).

Subd. 17c. **Replacement-costs-new per bed limit.** Notwithstanding subdivision 3f, paragraph (a), for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the replacement-costs-new per bed limit to be used in Minnesota Rules, part 9549.0060, subpart 4, item B, for a nursing facility that has completed a renovation, replacement, or upgrading project that has been approved under the moratorium exception process in section 144A.073, or that has completed an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost exceeds the lesser of $150,000 or ten percent of the most recent appraised value, must be $47,500 per licensed bed in multiple-bed rooms and $71,250 per licensed bed in a single-bed room. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 1993.

Subd. 17d. **Determination of rental per diem for total replacement projects.** (a) For purposes of this subdivision, a total replacement means the complete replacement of the nursing facility's physical plant through the construction of a new physical plant, the transfer of the nursing facility's license from one physical plant location to another, or a new building addition to relocate beds from three- and four-bed wards. For total replacement projects completed on or after July 1, 1992, the commissioner shall compute the incremental change in the nursing facility's rental per diem, for rate years beginning on or after July 1, 1995, by replacing its appraised value, including the historical capital asset costs, and the capital debt and interest costs with the new nursing facility's allowable capital asset costs and the related allowable capital debt and interest costs. If the new nursing facility has decreased its licensed capacity, the aggregate investment per bed limit in subdivision 3a, paragraph (c), shall apply.

(b) If the new nursing facility has retained a portion of the original physical plant for nursing facility usage, then a portion of the appraised value prior to the replacement must be retained and included in the calculation of the incremental change in the nursing facility's rental per diem. For purposes of this subdivision, the original nursing facility means the nursing facility prior to the total replacement project. The portion of the appraised value to be retained shall be calculated according to clauses (1) to (3):

(1) The numerator of the allocation ratio shall be the square footage of the area in the original physical plant which is being retained for nursing facility usage.

(2) The denominator of the allocation ratio shall be the total square footage of the original nursing facility physical plant.

(3) Each component of the nursing facility's allowable appraised value prior to the total replacement project shall be multiplied by the allocation ratio developed by dividing clause (1) by clause (2).

(c) In the case of either type of total replacement as authorized under section 144A.071 or 144A.073, the provisions of subdivisions 17 to 17f shall also apply.

(d) For purposes of the moratorium exception authorized under section 144A.071, subdivision 4a, paragraph (s), if the total replacement involves the renovation and use of an existing health care facility physical plant, the new allowable capital asset costs and related debt and interest costs shall include first the allowable capital asset costs and related debt and interest costs of the renovation, to which shall be added the allowable capital asset costs of the existing physical plant prior to the renovation, and if reported by the facility, the related allowable capital debt and interest costs.

Subd. 17e. **Replacement-costs-new per bed limit effective October 1, 2007.** Notwithstanding Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), for a total replacement, as defined in subdivision 17d, authorized under section 144A.071 or 144A.073 after July 1, 1999, any building project that is a relocation, renovation, upgrading, or conversion completed on or after July 1, 2001, or any building project eligible for reimbursement under section 256B.434, subdivision 4f, the replacement-costs-new per bed limit shall be $74,280 per licensed bed in multiple-bed rooms, $92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident beds, and $111,420 per licensed bed in single rooms. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 2000. These amounts must be increased annually as specified in subdivision 3f, paragraph (a), beginning October 1, 2012.

Subd. 18. **Updating appraisals, additions, and replacements.** (a) Notwithstanding Minnesota Rules, part 9549.0060, subparts 1 to 3, the appraised value, routine updating of the appraised value, and special reappraisals are subject to this subdivision.

For all rate years after June 30, 1993, the commissioner shall no longer conduct any appraisals under Minnesota Rules, part 9549.0060, for the purpose of determining property-related payment rates.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subpart 2, for rate years beginning after June 30, 1993, the commissioner shall routinely update the appraised value of each nursing facility by adding the cost of capital asset acquisitions to its allowable appraised value.

The commissioner shall also annually index each nursing facility's allowable appraised value by the inflation index referenced in subdivision 3f, paragraph (a), for the purpose of computing the nursing facility's annual rental rate. In annually adjusting the nursing facility's appraised value, the commissioner must not include the historical cost of capital assets acquired during the reporting year in the nursing facility's appraised value.

In addition, the nursing facility's appraised value must be reduced by the historical cost of capital asset disposals or applicable credits such as public grants and insurance proceeds. Capital asset additions and disposals must be reported on the nursing facility's annual cost report in the reporting year of acquisition or disposal. The incremental increase in the nursing facility's rental rate resulting from this annual adjustment as determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section shall be added to the nursing facility's property-related payment rate for the rate year following the reporting year.

Subd. 21. **Indexing thresholds.** Beginning January 1, 1993, and each January 1 thereafter, the commissioner shall annually update the dollar thresholds in subdivisions 15, paragraph (e), 16, and 17, and in section 144A.071, subdivisions 2 and 4a, clauses (b) and (e), by the inflation index referenced in subdivision 3f, paragraph (a).

Subd. 22. **Changes to nursing facility reimbursement.** In the determination of incremental increases in the nursing facility's rental rate as required in subdivisions 14 to 21, except for a refinancing permitted under subdivision 19, the commissioner must adjust the nursing facility's property-related payment rate for both incremental increases and decreases in recomputations of its rental rate.

Subd. 30. **Bed layaway and delicensure.** (a) For rate years beginning on or after July 1, 2000, a nursing facility reimbursed under this section which has placed beds on layaway shall, for purposes of application of the downsizing incentive in subdivision 3a, paragraph (c), and calculation of the rental per diem, have those beds given the same effect as if the beds had been delicensed so long as the beds remain on layaway. At the time of a layaway, a facility may change its single bed election

for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11. The property payment rate increase shall be effective the first day of the month of January or July, whichever occurs first following the date on which the layaway of the beds becomes effective under section 144A.071, subdivision 4b.

(b) For rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434 or chapter 256R, a nursing facility reimbursed under that section or chapter that has placed beds on layaway shall, for so long as the beds remain on layaway, be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) retain or change the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and

(3) establish capacity days based on the number of beds immediately prior to the layaway and the number of beds after the layaway.

The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the layaway of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 or chapter 256R completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4, paragraph (c). The property payment rate increase shall be effective the first day of the month of January or July, whichever occurs first following the date on which the layaway of the beds becomes effective.

(c) If a nursing facility removes a bed from layaway status in accordance with section 144A.071, subdivision 4b, the commissioner shall establish capacity days based on the number of licensed and certified beds in the facility not on layaway and shall reduce the nursing facility's property payment rate in accordance with paragraph (b).

(d) For the rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434 or chapter 256R, a nursing facility reimbursed under that section or chapter that has delicensed beds after July 1, 2000, by giving notice of the delicensure to the commissioner of health according to the notice requirements in section 144A.071, subdivision 4b, shall be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) retain or change the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and

(3) establish capacity days based on the number of beds immediately prior to the delicensure and the number of beds after the delicensure.

The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the delicensure of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4, paragraph (c). The property payment rate increase shall be effective the first day of the month of January or July, whichever occurs first following the date on which the delicensure of the beds becomes effective.

(e) For nursing facilities reimbursed under this section, section 256B.434, or chapter 256R, any beds placed on layaway shall not be included in calculating facility occupancy as it pertains to leave days defined in Minnesota Rules, part 9505.0415.

(f) For nursing facilities reimbursed under this section, section 256B.434, or chapter 256R, the rental rate calculated after placing beds on layaway may not be less than the rental rate prior to placing beds on layaway.

(g) A nursing facility receiving a rate adjustment as a result of this section shall comply with section 256R.06, subdivision 5.

(h) A facility that does not utilize the space made available as a result of bed layaway or delicensure under this subdivision to reduce the number of beds per room or provide more common space for nursing facility uses or perform other activities related to the operation of the nursing facility shall have its property rate increase calculated under this subdivision reduced by the ratio of the square footage made available that is not used for these purposes to the total square footage made available as a result of bed layaway or delicensure.

Subd. 45. **Rate adjustments for some moratorium exception projects.** Notwithstanding any other law to the contrary, money available for moratorium exception projects under section 144A.073, subdivisions 2 and 11, shall be used to fund the incremental rate increases resulting from this section for any nursing facility with a moratorium exception project approved under section 144A.073, and completed after August 30, 2010, where the replacement-costs-new limits under subdivision 17e were higher at any time after project approval than at the time of project completion. The commissioner shall calculate the property rate increase for these facilities using the highest set of limits; however, any rate increase under this section shall not be effective until on or after the effective date of this section, contingent upon federal approval. No property rate decrease shall result from this section.

**256B.434 ALTERNATIVE PAYMENT DEMONSTRATION PROJECT.**

Subd. 4. **Alternate rates for nursing facilities.** Effective for the rate years beginning on and after January 1, 2019, a nursing facility's property payment rate for the second and subsequent years of a facility's contract under this section are the previous rate year's property payment rate plus an inflation adjustment. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the Reports and Forecasts Division of the Department of Human Services, as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined.

Subd. 4f. **Construction project rate adjustments effective October 1, 2006.** (a) Effective October 1, 2006, facilities reimbursed under this section may receive a property rate adjustment for construction projects exceeding the threshold in section 256B.431, subdivision 16, and below the threshold in section 144A.071, subdivision 2, clause (a). For these projects, capital assets purchased shall be counted as construction project costs for a rate adjustment request made by a facility if they are: (1) purchased within 24 months of the completion of the construction project; (2) purchased after the completion date of any prior construction project; and (3) are not purchased prior to July 14, 2005. Except as otherwise provided in this subdivision, the definitions, rate calculation methods, and principles in sections 144A.071 and 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, shall be used to calculate rate adjustments for allowable construction projects under this subdivision and section 144A.073. Facilities completing construction projects between October 1, 2005, and October 1, 2006, are eligible to have a property rate adjustment effective October 1, 2006. Facilities completing projects after October 1, 2006, are eligible for a property rate adjustment effective on the first day of the month following the completion date. Facilities completing projects after January 1, 2018, are eligible for a property rate adjustment effective on the first day of the month of January or July, whichever occurs immediately following the completion date.

(b) Notwithstanding subdivision 18, as of July 14, 2005, facilities with rates set under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, that commenced a construction project on or after October 1, 2004, and do not have a contract under subdivision 3 by September 30, 2006, are eligible to request a rate adjustment under section 256B.431, subdivision 10, through September 30, 2006. If the request results in the commissioner determining a rate adjustment is allowable, the rate adjustment is effective on the first of the month following project completion. These facilities shall be allowed to accumulate construction project costs for the period October 1, 2004, to September 30, 2006.

(c) Facilities shall be allowed construction project rate adjustments no sooner than 12 months after completing a previous construction project. Facilities must request the rate adjustment according to section 256B.431, subdivision 10.

(d) Capacity days shall be computed according to Minnesota Rules, part 9549.0060, subpart 11. For rate calculations under this section, the number of licensed beds in the nursing facility shall be the number existing after the construction project is completed and the number of days in the nursing facility's reporting period shall be 365.

(e) The value of assets to be recognized for a total replacement project as defined in section 256B.431, subdivision 17d, shall be computed as described in clause (1). The value of assets to be recognized for all other projects shall be computed as described in clause (2).

(1) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the number of beds allowed under subdivision 3a, paragraph (c), shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation. If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved under section 144A.073, the assets to be used in the rate calculation cannot exceed the lesser of the amount determined under sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction project. A current request that is not the result of a project under section 144A.073 cannot exceed the limit under section 144A.071, subdivision 2, paragraph (a). Applicable credits must be deducted from the cost of the construction project.

(2)(i) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the number of beds allowed under section 256B.431, subdivision 3a, paragraph (c), shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation.

(ii) The value of a facility's assets to be compared to the amount in item (i) begins with the total appraised value from the last rate notice a facility received when its rates were set under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080. This value shall be indexed by the factor in section 256B.431, subdivision 3f, paragraph (a), for each rate year the facility received an inflation factor on its property-related rate when its rates were set under this section. The value of assets listed as previous capital additions, capital additions, and special projects on the facility's base year rate notice and the value of assets related to a construction project for which the facility received a rate adjustment when its rates were determined under this section shall be added to the indexed appraised value.

(iii) The maximum amount of assets to be recognized in computing a facility's rate adjustment after a project is completed is the lesser of the aggregate replacement-cost-new limit computed in (i) minus the assets recognized in (ii) or the actual allowable costs of the construction project.

(iv) If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved under section 144A.073, the assets to be added to the rate calculation cannot exceed the lesser of the amount determined under sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction project. A current request that is not the result of a project under section 144A.073 cannot exceed the limit stated in section 144A.071, subdivision 2, paragraph (a). Assets disposed of as a result of a construction project and applicable credits must be deducted from the cost of the construction project.

(f) For construction projects approved under section 144A.073, allowable debt may never exceed the lesser of the cost of the assets purchased, the threshold limit in section 144A.071, subdivision 2, or the replacement-cost-new limit less previously existing capital debt.

(g) For construction projects that were not approved under section 144A.073, allowable debt is limited to the lesser of the threshold in section 144A.071, subdivision 2, for such construction projects or the applicable limit in paragraph (e), clause (1) or (2), less previously existing capital debt. Amounts of debt taken out that exceed the costs of a construction project shall not be allowed regardless of the use of the funds.

For all construction projects being recognized, interest expense and average debt shall be computed based on the first 12 months following project completion. "Previously existing capital debt" means capital debt recognized on the last rate determined under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, and the amount of debt recognized for a construction project for which the facility received a rate adjustment when its rates were determined under this section.

For a total replacement project as defined in section 256B.431, subdivision 17d, the value of previously existing capital debt shall be zero.

(h) In addition to the interest expense allowed from the application of paragraph (f), the amounts allowed under section 256B.431, subdivision 17a, paragraph (a), clauses (2) and (3), will be added to interest expense.

(i) The equity portion of the construction project shall be computed as the allowable assets in paragraph (e), less the average debt in paragraph (f). The equity portion must be multiplied by 5.66

percent and the allowable interest expense in paragraph (f) must be added. This sum must be divided by 95 percent of capacity days to compute the construction project rate adjustment.

(j) For projects that are not a total replacement of a nursing facility, the amount in paragraph (i) is adjusted for nonreimbursable areas and then added to the current property payment rate of the facility.

(k) For projects that are a total replacement of a nursing facility, the amount in paragraph (i) becomes the new property payment rate after being adjusted for nonreimbursable areas. Any amounts existing in a facility's rate before the effective date of the construction project for equity incentives under section 256B.431, subdivision 16; capital repairs and replacements under section 256B.431, subdivision 15; or refinancing incentives under section 256B.431, subdivision 19, shall be removed from the facility's rates.

(l) No additional equipment allowance is allowed under Minnesota Rules, part 9549.0060, subpart 10, as the result of construction projects under this section. Allowable equipment shall be included in the construction project costs.

(m) Capital assets purchased after the completion date of a construction project shall be counted as construction project costs for any future rate adjustment request made by a facility under section 144A.071, subdivision 2, clause (a), if they are purchased within 24 months of the completion of the future construction project.

(n) In subsequent rate years, the property payment rate for a facility that results from the application of this subdivision shall be the amount inflated in subdivision 4.

(o) Construction projects are eligible for an equity incentive under section 256B.431, subdivision 16. When computing the equity incentive for a construction project under this subdivision, only the allowable costs and allowable debt related to the construction project shall be used. The equity incentive shall not be a part of the property payment rate and not inflated under subdivision 4. Effective October 1, 2006, all equity incentives for nursing facilities reimbursed under this section shall be allowed for a duration determined under section 256B.431, subdivision 16, paragraph (c).

Subd. 4i. **Construction project rate adjustments for certain nursing facilities.** (a) This subdivision applies to nursing facilities with at least 120 active beds as of January 1, 2015, that have projects approved in 2015 under the nursing facility moratorium exception process in section 144A.073. When each facility's moratorium exception construction project is completed, the facility must receive the rate adjustment allowed under subdivision 4f. In addition to that rate adjustment, facilities with at least 120 active beds, but not more than 149 active beds, as of January 1, 2015, must have their construction project rate adjustment increased by an additional $4; and facilities with at least 150 active beds, but not more than 160 active beds, as of January 1, 2015, must have their construction project rate adjustment increased by an additional $12.50.

(b) Notwithstanding any other law to the contrary, money available under section 144A.073, subdivision 11, after the completion of the moratorium exception approval process in 2015 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to the medical assistance budget for the increases allowed in this subdivision.

Subd. 4j. **Construction project rate increase for certain nursing facilities.** (a) This subdivision applies to nursing facilities:

(1) located in Ramsey County;

(2) with at least 130 active beds as of September 30, 2017;

(3) with a portion of beds dually certified for Medicare and Medicaid and a portion of beds certified for Medicaid only; and

(4) with debt service payments that are not being covered by the existing property payment rate on September 30, 2017.

(b) The commissioner shall increase the property rate of each facility meeting the qualifications of this subdivision by $7.55.

(c) Notwithstanding any other law to the contrary, money available under section 144A.073, subdivision 15, after the completion of the 2018 moratorium exception approval process under section 144A.073, subdivision 3, shall be used to pay the medical assistance cost for the property rate increase in this subdivision.

Subd. 6. **Contract payment rates; appeals.** If an appeal is pending concerning the cost-based payment rates that are the basis for the calculation of the payment rate under the alternative payment demonstration project, the commissioner and the nursing facility may agree on an interim contract rate to be used until the appeal is resolved. When the appeal is resolved, the contract rate must be adjusted retroactively in accordance with the appeal decision.

Subd. 10. **Exemptions.** A facility that is under contract with the commissioner under this section is not subject to the moratorium on licensure or certification of new nursing home beds in section 144A.071, unless the project results in a net increase in bed capacity or involves relocation of beds from one site to another. Contract payment rates must not be adjusted to reflect any additional costs that a nursing facility incurs as a result of a construction project undertaken under this subdivision. In addition, as a condition of entering into a contract under this section, a nursing facility must agree that any future medical assistance payments for nursing facility services will not reflect any additional costs attributable to the sale of a nursing facility under this section and to construction undertaken under this subdivision that otherwise would not be authorized under the moratorium in section 144A.073. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project under this section from seeking approval of an exception to the moratorium through the process established in section 144A.073, and if approved the facility's rates shall be adjusted to reflect the cost of the project. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project from seeking legislative approval of an exception to the moratorium under section 144A.071, and, if enacted, the facility's rates shall be adjusted to reflect the cost of the project.

**256B.4913 PAYMENT METHODOLOGY DEVELOPMENT.**

Subd. 4a. **Rate stabilization adjustment.** (a) For purposes of this subdivision, "implementation period" means the period beginning January 1, 2014, and ending on the last day of the month in which the rate management system is populated with the data necessary to calculate rates for substantially all individuals receiving home and community-based waiver services under sections 256B.092 and 256B.49. "Banding period" means the time period beginning on January 1, 2014, and ending upon the expiration of the 12-month period defined in paragraph (c), clause (5).

(b) For purposes of this subdivision, the historical rate for all service recipients means the individual reimbursement rate for a recipient in effect on December 1, 2013, except that:

(1) for a day service recipient who was not authorized to receive these waiver services prior to January 1, 2014; added a new service or services on or after January 1, 2014; or changed providers on or after January 1, 2014, the historical rate must be the weighted average authorized rate for the provider number in the county of service, effective December 1, 2013; or

(2) for a unit-based service with programming or a unit-based service without programming recipient who was not authorized to receive these waiver services prior to January 1, 2014; added a new service or services on or after January 1, 2014; or changed providers on or after January 1, 2014, the historical rate must be the weighted average authorized rate for each provider number in the county of service, effective December 1, 2013; or

(3) for residential service recipients who change providers on or after January 1, 2014, the historical rate must be set by each lead agency within their county aggregate budget using their respective methodology for residential services effective December 1, 2013, for determining the provider rate for a similarly situated recipient being served by that provider.

(c) The commissioner shall adjust individual reimbursement rates determined under this section so that the unit rate is no higher or lower than:

(1) 0.5 percent from the historical rate for the implementation period;

(2) 0.5 percent from the rate in effect in clause (1), for the 12-month period immediately following the time period of clause (1);

(3) 0.5 percent from the rate in effect in clause (2), for the 12-month period immediately following the time period of clause (2);

(4) 1.0 percent from the rate in effect in clause (3), for the 12-month period immediately following the time period of clause (3);

(5) 1.0 percent from the rate in effect in clause (4), for the 12-month period immediately following the time period of clause (4);

(6) no adjustment to the rate in effect in clause (5) for the 12-month period immediately following the time period of clause (5). During this banding rate period, the commissioner shall not enforce any rate decrease or increase that would otherwise result from the end of the banding period. The commissioner shall, upon enactment, seek federal approval for the addition of this banding period; and

(7) one percent from the rate in effect in clause (6) for the 12-month period immediately following the time period of clause (6).

(d) The commissioner shall review all changes to rates that were in effect on December 1, 2013, to verify that the rates in effect produce the equivalent level of spending and service unit utilization on an annual basis as those in effect on October 31, 2013.

(e) By December 31, 2014, the commissioner shall complete the review in paragraph (d), adjust rates to provide equivalent annual spending, and make appropriate adjustments.

(f) During the banding period, the Medicaid Management Information System (MMIS) service agreement rate must be adjusted to account for change in an individual's need. The commissioner shall adjust the Medicaid Management Information System (MMIS) service agreement rate by:

(1) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the individual with variables reflecting the level of service in effect on December 1, 2013;

(2) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the individual with variables reflecting the updated level of service at the time of application; and

(3) adding to or subtracting from the Medicaid Management Information System (MMIS) service agreement rate, the difference between the values in clauses (1) and (2).

(g) This subdivision must not apply to rates for recipients served by providers new to a given county after January 1, 2014. Providers of personal supports services who also acted as fiscal support entities must be treated as new providers as of January 1, 2014.

Subd. 6. **Implementation.** (a) The commissioner shall implement changes on January 1, 2014, to payment rates for individuals receiving home and community-based waivered services after the enactment of legislation that establishes specific payment methodology frameworks, processes for rate calculations, and specific values to populate the disability waiver rates system.

(b) On January 1, 2014, all new service authorizations must use the disability waiver rates system. Beginning January 1, 2014, all renewing individual service plans must use the disability waiver rates system as reassessment and reauthorization occurs. By December 31, 2014, data for all recipients must be entered into the disability waiver rates system.

Subd. 7. **New services.** A service added to section 256B.4914 after January 1, 2014, is not subject to rate stabilization adjustment in this section.

**256L.11 PROVIDER PAYMENT.**

Subd. 2a. **Payment rates; services for families and children under the MinnesotaCare health care reform waiver.** Subdivision 2 shall not apply to services provided to families with children who are eligible according to section 256L.04, subdivision 1, paragraph (a).

Subd. 6a. **Dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after January 1, 2018, the commissioner shall increase payment rates to dental providers by 54 percent. Payments made to prepaid health plans under section 256L.12 shall reflect the payment increase described in this subdivision. The prepaid health plans under contract with the commissioner shall provide payments to dental providers that are at least equal to a rate that includes the payment rate specified in this subdivision, and if applicable to the provider, the rates described under subdivision 7.

**256R.36 HOLD HARMLESS.**

No nursing facility's operating payment rate, plus its employer health insurance costs portion of the external fixed costs payment rate, will be less than its prior system operating cost payment rate.

**256R.40 NURSING FACILITY VOLUNTARY CLOSURE; ALTERNATIVES.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Closure" means the cessation of operations of a nursing facility and delicensure and decertification of all beds within the facility.

(c) "Closure plan" means a plan to close a nursing facility and reallocate a portion of the resulting savings to provide planned closure rate adjustments at other facilities.

(d) "Commencement of closure" means the date on which residents and designated representatives are notified of a planned closure as provided in section 144A.161, subdivision 5a, as part of an approved closure plan.

(e) "Completion of closure" means the date on which the final resident of the nursing facility designated for closure in an approved closure plan is discharged from the facility or the date that beds from a partial closure are delicensed and decertified.

(f) "Partial closure" means the delicensure and decertification of a portion of the beds within the facility.

(g) "Planned closure rate adjustment" means an increase in a nursing facility's operating rates resulting from a planned closure or a planned partial closure of another facility.

Subd. 2. **Applications for planned closure rate.** (a) To be considered for approval of a planned closure, an application must include:

(1) a description of the proposed closure plan, which must include identification of the facility or facilities to receive a planned closure rate adjustment;

(2) the proposed timetable for any proposed closure, including the proposed dates for announcement to residents, commencement of closure, and completion of closure;

(3) if available, the proposed relocation plan for current residents of any facility designated for closure. If a relocation plan is not available, the application must include a statement agreeing to develop a relocation plan designed to comply with section 144A.161;

(4) a description of the relationship between the nursing facility that is proposed for closure and the nursing facility or facilities proposed to receive the planned closure rate adjustment. If these facilities are not under common ownership, copies of any contracts, purchase agreements, or other documents establishing a relationship or proposed relationship must be provided; and

(5) documentation, in a format approved by the commissioner, that all the nursing facilities receiving a planned closure rate adjustment under the plan have accepted joint and several liability for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under the plan.

(b) The application must also address the criteria listed in subdivision 3.

Subd. 3. **Criteria for review of application.** In reviewing and approving closure proposals, the commissioner shall consider, but not be limited to, the following criteria:

(1) improved quality of care and quality of life for consumers;

(2) closure of a nursing facility that has a poor physical plant;

(3) the existence of excess nursing facility beds, measured in terms of beds per thousand persons aged 85 or older. The excess must be measured in reference to:

(i) the county in which the facility is located. A facility in a county that is in the lowest quartile of counties with reference to beds per thousand persons aged 85 or older is not in an area of excess capacity;

(ii) the county and all contiguous counties;

(iii) the region in which the facility is located; or

(iv) the facility's service area. The facility shall indicate in its application the service area it believes is appropriate for this measurement;

(4) low-occupancy rates, provided that the unoccupied beds are not the result of a personnel shortage. In analyzing occupancy rates, the commissioner shall examine waiting lists in the applicant facility and at facilities in the surrounding area, as determined under clause (3);

(5) evidence of coordination between the community planning process and the facility application. If the planning group does not support a level of nursing facility closures that the commissioner

considers to be reasonable, the commissioner may approve a planned closure proposal without its support;

(6) proposed usage of funds available from a planned closure rate adjustment for care-related purposes;

(7) innovative use planned for the closed facility's physical plant;

(8) evidence that the proposal serves the interests of the state; and

(9) evidence of other factors that affect the viability of the facility, including excessive nursing pool costs.

Subd. 4. **Review and approval of applications.** (a) The commissioner, in consultation with the commissioner of health, shall approve or deny an application within 30 days after receiving it. The commissioner may appoint an advisory review panel composed of representatives of counties, consumers, and providers to review proposals and provide comments and recommendations to the committee. The commissioners of human services and health shall provide staff and technical assistance to the committee for the review and analysis of proposals.

(b) Approval of a planned closure expires 18 months after approval by the commissioner unless commencement of closure has begun.

(c) The commissioner may change any provision of the application to which the applicant, the regional planning group, and the commissioner agree.

Subd. 5. **Planned closure rate adjustment.** (a) The commissioner shall calculate the amount of the planned closure rate adjustment available under subdivision 6 according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month of January or July, whichever occurs immediately following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's external fixed payment rate.

(c) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

(d) A facility that has received a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment is computed according to paragraph (a).

(e) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the commissioner shall recalculate planned closure rate adjustments for facilities that delicense beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar amount. The recalculated planned closure rate adjustment is effective from the date the per bed dollar amount is increased.

Subd. 6. **Assignment of closure rate to another facility.** A facility or facilities reimbursed under this chapter with a closure plan approved by the commissioner under subdivision 4 may assign a planned closure rate adjustment to another facility or facilities that are not closing or in the case of a partial closure, to the facility undertaking the partial closure. A facility may also elect to have a planned closure rate adjustment shared equally by the five nursing facilities with the lowest total operating payment rates in the state development region designated under section 462.385, in which the facility that is closing is located. The planned closure rate adjustment must be calculated under subdivision 5. Facilities that delicense beds without a closure plan, or whose closure plan is not approved by the commissioner, are not eligible to assign a planned closure rate adjustment under subdivision 5, unless they: (1) are delicensing five or fewer beds, or less than six percent of their total licensed bed capacity, whichever is greater; (2) are located in a county in the top three quartiles of beds per 1,000 persons aged 65 or older; and (3) have not delicensed beds in

the prior three months. Facilities meeting these criteria are eligible to assign the amount calculated under subdivision 5 to themselves. If a facility is delicensing the greater of six or more beds, or six percent or more of its total licensed bed capacity, and does not have an approved closure plan or is not eligible for the adjustment under subdivision 5, the commissioner shall calculate the amount the facility would have been eligible to assign under subdivision 5, and shall use this amount to provide equal rate adjustments to the five nursing facilities with the lowest total operating payment rates in the state development region designated under section 462.385, in which the facility that delicensed beds is located.

Subd. 7. **Other rate adjustments.** Facilities receiving planned closure rate adjustments remain eligible for any applicable rate adjustments provided under this chapter.

**256R.41 SINGLE-BED ROOM INCENTIVE.**

(a) Beginning July 1, 2005, the operating payment rate for nursing facilities reimbursed under this chapter shall be increased by 20 percent multiplied by the ratio of the number of new single-bed rooms created divided by the number of active beds on July 1, 2005, for each bed closure that results in the creation of a single-bed room after July 1, 2005. The commissioner may implement rate adjustments for up to 3,000 new single-bed rooms each year. For eligible bed closures for which the commissioner receives a notice from a facility that a bed has been delicensed and a new single-bed room has been established, the rate adjustment in this paragraph shall be effective on either the first day of the month of January or July, whichever occurs first following the date of the bed delicensure.

(b) A nursing facility is prohibited from discharging residents for purposes of establishing single-bed rooms. A nursing facility must submit documentation to the commissioner in a form prescribed by the commissioner, certifying the occupancy status of beds closed to create single-bed rooms. In the event that the commissioner determines that a facility has discharged a resident for purposes of establishing a single-bed room, the commissioner shall not provide a rate adjustment under paragraph (a).

***Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 10***

Sec. 3. **COMMISSIONER OF HUMAN SERVICES**

Subd. 10. **State-Operated Services**

**Obsolete Laundry Depreciation Account.** $669,000, or the balance, whichever is greater, must be transferred from the state-operated services laundry depreciation account in the special revenue fund and deposited into the general fund by June 30, 2010. This paragraph is effective the day following final enactment.

**Operating Budget Reductions.** No operating budget reductions enacted in Laws 2010, chapter 200, or in this act shall be allocated to state-operated services.

**Prohibition on Transferring Funds.** The commissioner shall not transfer mental health grants to state-operated services without specific legislative approval. Notwithstanding any contrary provision in this article, this paragraph shall not expire.

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| (a) **Adult Mental Health Services** | -0- | 6,888,000 |

**Base Adjustment.** The general fund base is decreased by $12,286,000 in fiscal year 2012 and $12,394,000 in fiscal year 2013.

**Appropriation Requirements.** (a) The general fund appropriation to the commissioner includes funding for the following:

(1) to a community collaborative to begin providing crisis center services in the Mankato area that are comparable to the crisis services provided prior to the closure of the Mankato Crisis Center. The commissioner shall recruit former employees of the Mankato Crisis Center who were recently laid off to staff the new crisis services. The commissioner shall obtain legislative approval prior to discontinuing this funding;

(2) to maintain the building in Eveleth that currently houses community transition services and to establish a psychiatric intensive therapeutic foster home as an enterprise activity. The commissioner shall request a waiver amendment to allow CADI funding for psychiatric intensive therapeutic foster care services provided in the same location and building as the community transition services. If the federal government does not approve the waiver amendment, the commissioner shall continue to pay the lease for the building out of the state-operated services budget until the commissioner of administration subleases the space or until the lease expires, and shall establish the psychiatric intensive therapeutic foster home at a different site. The commissioner shall make diligent efforts to sublease the space;

(3) to convert the community behavioral health hospitals in Wadena and Willmar to facilities that

provide more suitable services based on the needs of the community, which may include, but are not limited to, psychiatric extensive recovery treatment services. The commissioner may also establish other community-based services in the Willmar and Wadena areas that deliver the appropriate level of care in response to the express needs of the communities. The services established under this provision must be staffed by state employees.

(4) to continue the operation of the dental clinics in Brainerd, Cambridge, Faribault, Fergus Falls, and Willmar at the same level of care and staffing that was in effect on March 1, 2010. The commissioner shall not proceed with the planned closure of the dental clinics, and shall not discontinue services or downsize any of the state-operated dental clinics without specific legislative approval. The commissioner shall continue to bill for services provided to obtain medical assistance critical access dental payments and cost-based payment rates as provided in Minnesota Statutes, section 256B.76, subdivision 2, and shall bill for services provided three months retroactively from the date of this act. This appropriation is onetime;

(5) to convert the Minnesota Neurorehabilitation Hospital in Brainerd to a neurocognitive psychiatric extensive recovery treatment service; and

(6) to convert the Minnesota extended treatment options (METO) program to the following community-based services provided by state employees: (i) psychiatric extensive recovery treatment services; (ii) intensive transitional foster homes as enterprise activities; and (iii) other community-based support services. The provisions under Minnesota Statutes, section 252.025, subdivision 7, are applicable to the METO services established under this clause. Notwithstanding Minnesota Statutes, section 246.18, subdivision 8, any revenue lost to the general fund by the conversion of METO to new services must be replaced by revenue from the new services to offset the lost revenue to the general fund until June 30, 2013. Any revenue generated in excess of this amount shall be deposited into the special revenue fund under Minnesota Statutes, section 246.18, subdivision 8.

(b) The commissioner shall not move beds from the Anoka-Metro Regional Treatment Center to the psychiatric nursing facility at St. Peter without specific legislative approval.

(c) The commissioner shall implement changes, including the following, to save a minimum of $6,006,000 beginning in fiscal year 2011, and report to the legislature the specific initiatives implemented and the savings allocated to each one, including:

(1) maximizing budget savings through strategic employee staffing; and

(2) identifying and implementing cost reductions in cooperation with state-operated services employees.

Base level funding is reduced by $6,006,000 effective fiscal year 2011.

(d) The commissioner shall seek certification or approval from the federal government for the new services under paragraph (a) that are eligible for federal financial participation and deposit the revenue associated with these new services in the account established under Minnesota Statutes, section 246.18, subdivision 8, unless otherwise specified.

(e) Notwithstanding any contrary provision in this article, this rider shall not expire.

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| (b) **Minnesota Sex Offender Services** | -0- | (145,000) |

**Sex Offender Services.** Base level funding for Minnesota sex offender services is reduced by $418,000 in fiscal year 2012 and $419,000 in fiscal year 2013 for the 50-bed sex offender treatment program within the Moose Lake correctional facility in which Department of Human Services staff from Minnesota sex offender services provide clinical treatment to incarcerated offenders. This reduction shall become part of the base for the Department of Human Services.

**Interagency Agreements.** The commissioner of human services may enter into interagency agreements with the commissioner of corrections to continue sex offender treatment and chemical dependency treatment on a cost-sharing basis, in which each department pays 50 percent of the costs of these services.

**Base Adjustment.** The general fund base is increased by $418,000 in fiscal year 2012 and $419,000 in fiscal year 2013.

***Laws 2011, First Special Session chapter 9, article 6, section 97, subdivision 6***

Sec. 97. **REPEALER.**

Subd. 6. **MinnesotaCare provider taxes.** Minnesota Statutes 2010, sections 13.4967, subdivision 3; 295.50, subdivisions 1, 1a, 2, 2a, 3, 4, 6, 6a, 7, 9b, 9c, 10a, 10b, 12b, 13, 14, and 15; 295.51, subdivisions 1 and 1a; 295.52, subdivisions 1, 1a, 2, 3, 4, 4a, 5, 6, and 7; 295.53, subdivisions 1, 2, 3, and 4a; 295.54; 295.55; 295.56; 295.57; 295.58; 295.581; 295.582; and 295.59, are repealed effective for gross revenues received after December 31, 2019.

**2960.3030 CAPACITY LIMITS.**

Subp. 3. **Exceptions to capacity limits.** A variance may be granted to allow up to eight foster children in addition to the license holder's own children if the conditions in items A to E are met:

A. placement is necessary to keep a sibling group together, to keep a child in the child's home community, or is necessary because the foster child was formerly living in the home and it would be in the child's best interest to be placed there again;

B. there is no risk of harm to the children currently in the home;

C. the structural characteristics of the home, including sleeping space, can accommodate the additional foster children;

D. the home remains in compliance with applicable zoning, health, fire, and building codes; and

E. the statement of intended use states the conditions for the exception to capacity limits and explains how the license holder will maintain a ratio of adults to children which ensures the safety and appropriate supervision of all the children in the foster home.

A foster home licensed by the Department of Corrections need not meet the requirement in item A.

**3400.0185 TERMINATION AND ADVERSE ACTIONS; NOTICE REQUIRED.**

Subp. 5. **Notice to providers of actions adverse to the provider.** The county must give a provider written notice of the following actions adverse to the provider: a denial of authorization, a termination of authorization, a reduction in the number of hours of care with that provider, and a determination that the provider has an overpayment. The notice must include the following information:

A. a description of the adverse action;

B. the effective date of the adverse action; and

C. a statement that unless a family appeals the adverse action before the effective date or the provider appeals the overpayment determination, the adverse action will occur on the effective date. The notice must be mailed to the provider at least 15 calendar days before the effective date of the adverse action.

**6400.6970 FEES.**

Subpart 1. **Payment types and nonrefundability.** The fees imposed in this part shall be paid by cash, personal check, bank draft, cashier's check, or money order made payable to the Board of Examiners for Nursing Home Administrators. All fees are nonrefundable.

Subp. 2. **Amounts.** The amount of fees may be set by the board with the approval of the Department of Management and Budget up to the limits provided in this part depending upon the total amount required to sustain board operations under Minnesota Statutes, section 16A.1285, subdivision 2. Information about fees in effect at any time is available from the board office. The maximum amounts of fees are:

A. application for licensure, $150;

B. for a prospective applicant for a review of education and experience advisory to the license application, $50, to be applied to the fee for application for licensure if the latter is submitted within one year of the request for review of education and experience;

C. state examination, $75;

D. initial license, $200 if issued between July 1 and December 31, $100 if issued between January 1 and June 30;

E. acting administrator permit, $250;

F. renewal license, $200;

G. duplicate license, $10;

H. fee to a sponsor for review of individual continuing education seminars, institutes, workshops, or home study courses:

(1) for less than seven clock hours, $30; and

(2) for seven or more clock hours, $50;

I. fee to a licensee for review of continuing education seminars, institutes, workshops, or home study courses not previously approved for a sponsor and submitted with an application for license renewal:

(1) for less than seven clock hours total, $30; and

(2) for seven or more clock hours total, $50;

J. late renewal fee, $50;

K. fee to a licensee for verification of licensure status and examination scores, $30; and

L. registration as a registered continuing education sponsor, $1,000.

**7200.6100 FEES.**

The nonrefundable fees for licensure payable to the board are as follows:

A. application for admission to national standardized examination, $150;

B. application for professional responsibility examination, $150;

C. application for licensure as a licensed psychologist, $500;

D. renewal of license for a licensed psychologist, $500;

E. late renewal of license for a licensed psychologist, $250;

F. application for converting from master's to doctoral level licensure, $150; and

G. application for guest licensure, $150.

**7200.6105 CONTINUING EDUCATION SPONSOR FEE.**

A sponsor applying for approval of a continuing education activity pursuant to part 7200.3830, subpart 2, shall submit with the application a fee of $80 for each activity.

**9502.0425 PHYSICAL ENVIRONMENT.**

Subp. 4. **Means of escape.** From each room of the residence used by children, there must be two means of escape. One means of escape must be a stairway or door leading to the floor of exit discharge. The other must be a door or window leading directly outside. The window must be openable without special knowledge. It must have a clear opening of not less than 5.7 square feet and have a minimum clear opening dimension of 20 inches wide and 24 inches high. The window must be within 48 inches from the floor.

Subp. 16. **Extinguishers.** A portable, operational, multipurpose, dry chemical fire extinguisher with a minimum 2 A 10 BC rating must be maintained in the kitchen and cooking areas of the residence at all times. All caregivers shall know how to use the fire extinguisher.

Subp. 17. **Smoke detection systems.** Smoke detectors that have been listed by the Underwriter Laboratory must be properly installed and maintained on all levels.

**9503.0155 FACILITY.**

Subp. 8. **Telephone; posted numbers.** A telephone that is not coin operated must be located within the center. A list of emergency numbers must be posted next to the telephone. If a 911 emergency number is not available, the numbers listed must be those of the local fire department, police department, emergency transportation, and poison control center.

**9505.0370 DEFINITIONS.**

Subpart 1. **Scope.** For parts 9505.0370 to 9505.0372, the following terms have the meanings given them.

Subp. 2. **Adult day treatment.** "Adult day treatment" or "adult day treatment program" means a structured program of treatment and care.

Subp. 3. **Child.** "Child" means a person under 18 years of age.

Subp. 4. **Client.** "Client" means an eligible recipient who is determined to have or who is being assessed for a mental illness as specified in part 9505.0371.

Subp. 5. **Clinical summary.** "Clinical summary" means a written description of a clinician's formulation of the cause of the client's mental health symptoms, the client's prognosis, and the likely consequences of the symptoms; how the client meets the criteria for the diagnosis by describing the client's symptoms, the duration of symptoms, and functional impairment; an analysis of the client's other symptoms, strengths, relationships, life situations, cultural influences, and health concerns and their potential interaction with the diagnosis and formulation of the client's mental health condition; and alternative diagnoses that were considered and ruled out.

Subp. 6. **Clinical supervision.** "Clinical supervision" means the documented time a clinical supervisor and supervisee spend together to discuss the supervisee's work, to review individual client cases, and for the supervisee's professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a client's mental health treatment.

Subp. 7. **Clinical supervisor.** "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.

Subp. 8. **Cultural competence or culturally competent.** "Cultural competence" or "culturally competent" means the mental health provider's:

A. awareness of the provider's own cultural background, and the related assumptions, values, biases, and preferences that influence assessment and intervention processes;

B. ability and will to respond to the unique needs of an individual client that arise from the client's culture;

C. ability to utilize the client's culture as a resource and as a means to optimize mental health care; and

D. willingness to seek educational, consultative, and learning experiences to expand knowledge of and increase effectiveness with culturally diverse populations.

Subp. 9. **Cultural influences.** "Cultural influences" means historical, geographical, and familial factors that affect assessment and intervention processes. Cultural influences that are relevant to the client may include the client's:

A. racial or ethnic self-identification;

B. experience of cultural bias as a stressor;

C. immigration history and status;

D. level of acculturation;

E. time orientation;

F. social orientation;

G. verbal communication style;

H. locus of control;

I. spiritual beliefs; and

J. health beliefs and the endorsement of or engagement in culturally specific healing practices.

Subp. 10. **Culture.** "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

Subp. 11. **Diagnostic assessment.** "Diagnostic assessment" means a written assessment that documents a clinical and functional face-to-face evaluation of the client's mental health, including the nature, severity and impact of behavioral difficulties, functional impairment, and subjective distress of the client, and identifies the client's strengths and resources.

Subp. 12. **Dialectical behavior therapy.** "Dialectical behavior therapy" means an evidence-based treatment approach provided in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program is certified by the commissioner and involves the following service components: individual dialectical behavior therapy, group skills training, telephone coaching, and team consultation meetings.

Subp. 13. **Explanation of findings.** "Explanation of findings" means the explanation of a client's diagnostic assessment, psychological testing, treatment program, and consultation with culturally informed mental health consultants as required under parts 9520.0900 to 9520.0926, or other accumulated data and recommendations to the client, client's family, primary caregiver, or other responsible persons.

Subp. 14. **Family.** "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, or persons who are presently residing together as a family unit.

Subp. 15. **Individual treatment plan.** "Individual treatment plan" means a written plan that outlines and defines the course of treatment. It delineates the goals, measurable objectives, target dates for achieving specific goals, main participants in treatment process, and recommended services that are based on the client's diagnostic assessment and other meaningful data that are needed to aid the client's recovery and enhance resiliency.

Subp. 16. **Medication management.** "Medication management" means a service that determines the need for or effectiveness of the medication prescribed for the treatment of a client's symptoms of a mental illness.

Subp. 17. **Mental health practitioner.** "Mental health practitioner" means a person who is qualified according to part 9505.0371, subpart 5, items B and C, and provides mental health services to a client with a mental illness under the clinical supervision of a mental health professional.

Subp. 18. **Mental health professional.** "Mental health professional" means a person who is enrolled to provide medical assistance services and is qualified according to part 9505.0371, subpart 5, item A.

Subp. 19. **Mental health telemedicine.** "Mental health telemedicine" has the meaning given in Minnesota Statutes, section 256B.0625, subdivision 46.

Subp. 20. **Mental illness.** "Mental illness" has the meaning given in Minnesota Statutes, section 245.462, subdivision 20. "Mental illness" includes "emotional disturbance" as defined in Minnesota Statutes, section 245.4871, subdivision 15.

Subp. 21. **Multidisciplinary staff.** "Multidisciplinary staff" means a group of individuals from diverse disciplines who come together to provide services to clients under part 9505.0372, subparts 8, 9, and 10.

Subp. 22. **Neuropsychological assessment.** "Neuropsychological assessment" means a specialized clinical assessment of the client's underlying cognitive abilities related to thinking, reasoning, and judgment that is conducted by a qualified neuropsychologist.

Subp. 23. **Neuropsychological testing.** "Neuropsychological testing" means administering standardized tests and measures designed to evaluate the client's ability to attend to, process, interpret, comprehend, communicate, learn and recall information; and use problem-solving and judgment.

Subp. 24. **Partial hospitalization program.** "Partial hospitalization program" means a provider's time-limited, structured program of psychotherapy and other therapeutic services, as defined in United States Code, title 42, chapter 7, subchapter XVIII, part E, section 1395x, (ff), that is provided in an outpatient hospital facility or community mental health center that meets Medicare requirements to provide partial hospitalization services.

Subp. 25. **Primary caregiver.** "Primary caregiver" means a person, other than the facility staff, who has primary legal responsibility for providing the client with food, clothing, shelter, direction, guidance, and nurturance.

Subp. 26. **Psychological testing.** "Psychological testing" means the use of tests or other psychometric instruments to determine the status of the recipient's mental, intellectual, and emotional functioning.

Subp. 27. **Psychotherapy.** "Psychotherapy" means treatment of a client with mental illness that applies the most appropriate psychological, psychiatric, psychosocial, or interpersonal method that conforms to prevailing community standards of professional practice to meet the mental health needs of the client.

Subp. 28. **Supervisee.** "Supervisee" means an individual who requires clinical supervision because the individual does not meet mental health professional standards in part 9505.0371, subpart 5, item A.

## 9505.0371 MEDICAL ASSISTANCE COVERAGE REQUIREMENTS FOR OUTPATIENT MENTAL HEALTH SERVICES.

Subpart 1. **Purpose.** This part describes the requirements that outpatient mental health services must meet to receive medical assistance reimbursement.

Subp. 2. **Client eligibility for mental health services.** The following requirements apply to mental health services:

A. The provider must use a diagnostic assessment as specified in part 9505.0372 to determine a client's eligibility for mental health services under this part, except:

(1) prior to completion of a client's initial diagnostic assessment, a client is eligible for:

(a) one explanation of findings;

(b) one psychological testing; and

(c) either one individual psychotherapy session, one family psychotherapy session, or one group psychotherapy session; and

(2) for a client who is not currently receiving mental health services covered by medical assistance, a crisis assessment as specified in Minnesota Statutes, section

256B.0624 or 256B.0944, conducted in the past 60 days may be used to allow up to ten sessions of mental health services within a 12-month period.

B. A brief diagnostic assessment must meet the requirements of part 9505.0372, subpart 1, item D, and:

(1) may be used to allow up to ten sessions of mental health services as specified in part 9505.0372 within a 12-month period before a standard or extended diagnostic assessment is required when the client is:

(a) a new client; or

(b) an existing client who has had fewer than ten sessions of psychotherapy in the previous 12 months and is projected to need fewer than ten sessions of psychotherapy in the next 12 months, or who only needs medication management; and

(2) may be used for a subsequent annual assessment, if based upon the client's treatment history and the provider's clinical judgment, the client will need ten or fewer sessions of mental health services in the upcoming 12-month period; and

(3) must not be used for:

(a) a client or client's family who requires a language interpreter to participate in the assessment unless the client meets the requirements of subitem (1), unit (b), or (2); or

(b) more than ten sessions of mental health services in a 12-month period. If, after completion of ten sessions of mental health services, the mental health professional determines the need for additional sessions, a standard assessment or extended assessment must be completed.

C. For a child, a new standard or extended diagnostic assessment must be completed:

(1) when the child does not meet the criteria for a brief diagnostic assessment;

(2) at least annually following the initial diagnostic assessment, if:

(a) additional services are needed; and

(b) the child does not meet criteria for brief assessment;

(3) when the child's mental health condition has changed markedly since the child's most recent diagnostic assessment; or

(4) when the child's current mental health condition does not meet criteria of the child's current diagnosis.

D. For an adult, a new standard diagnostic assessment or extended diagnostic assessment must be completed:

(1) when the adult does not meet the criteria for a brief diagnostic assessment or an adult diagnostic assessment update;

(2) at least every three years following the initial diagnostic assessment for an adult who receives mental health services;

(3) when the adult's mental health condition has changed markedly since the adult's most recent diagnostic assessment; or

(4) when the adult's current mental health condition does not meet criteria of the current diagnosis.

E. An adult diagnostic assessment update must be completed at least annually unless a new standard or extended diagnostic assessment is performed. An adult diagnostic assessment update must include an update of the most recent standard or extended diagnostic

assessment and any recent adult diagnostic assessment updates that have occurred since the last standard or extended diagnostic assessment.

Subp. 3. **Authorization for mental health services.** Mental health services under this part are subject to authorization criteria and standards published by the commissioner according to Minnesota Statutes, section 256B.0625, subdivision 25.

Subp. 4. **Clinical supervision.**

A. Clinical supervision must be based on each supervisee's written supervision plan and must:

(1) promote professional knowledge, skills, and values development;

(2) model ethical standards of practice;

(3) promote cultural competency by:

(a) developing the supervisee's knowledge of cultural norms of behavior for individual clients and generally for the clients served by the supervisee regarding the client's cultural influences, age, class, gender, sexual orientation, literacy, and mental or physical disability;

(b) addressing how the supervisor's and supervisee's own cultures and privileges affect service delivery;

(c) developing the supervisee's ability to assess their own cultural competence and to identify when consultation or referral of the client to another provider is needed; and

(d) emphasizing the supervisee's commitment to maintaining cultural competence as an ongoing process;

(4) recognize that the client's family has knowledge about the client and will continue to play a role in the client's life and encourage participation among the client, client's family, and providers as treatment is planned and implemented; and

(5) monitor, evaluate, and document the supervisee's performance of assessment, treatment planning, and service delivery.

B. Clinical supervision must be conducted by a qualified supervisor using individual or group supervision. Individual or group face-to-face supervision may be conducted via electronic communications that utilize interactive telecommunications equipment that includes at a minimum audio and video equipment for two-way, real-time, interactive communication between the supervisor and supervisee, and meet the equipment and connection standards of part 9505.0370, subpart 19.

(1) Individual supervision means one or more designated clinical supervisors and one supervisee.

(2) Group supervision means one clinical supervisor and two to six supervisees in face-to-face supervision.

C. The supervision plan must be developed by the supervisor and the supervisee. The plan must be reviewed and updated at least annually. For new staff the plan must be completed and implemented within 30 days of the new staff person's employment. The supervision plan must include:

(1) the name and qualifications of the supervisee and the name of the agency in which the supervisee is being supervised;

(2) the name, licensure, and qualifications of the supervisor;

(3) the number of hours of individual and group supervision to be completed by the supervisee including whether supervision will be in person or by some other method approved by the commissioner;

(4) the policy and method that the supervisee must use to contact the clinical supervisor during service provision to a supervisee;

(5) procedures that the supervisee must use to respond to client emergencies; and

(6) authorized scope of practices, including:

(a) description of the supervisee's service responsibilities;

(b) description of client population; and

(c) treatment methods and modalities.

D. Clinical supervision must be recorded in the supervisee's supervision record. The documentation must include:

(1) date and duration of supervision;

(2) identification of supervision type as individual or group supervision;

(3) name of the clinical supervisor;

(4) subsequent actions that the supervisee must take; and

(5) date and signature of the clinical supervisor.

E. Clinical supervision pertinent to client treatment changes must be recorded by a case notation in the client record after supervision occurs.

Subp. 5. **Qualified providers.** Medical assistance covers mental health services according to part 9505.0372 when the services are provided by mental health professionals or mental health practitioners qualified under this subpart.

A. A mental health professional must be qualified in one of the following ways:

(1) in clinical social work, a person must be licensed as an independent clinical social worker by the Minnesota Board of Social Work under Minnesota Statutes, chapter 148D until August 1, 2011, and thereafter under Minnesota Statutes, chapter 148E;

(2) in psychology, a person licensed by the Minnesota Board of Psychology under Minnesota Statutes, sections 148.88 to 148.98, who has stated to the board competencies in the diagnosis and treatment of mental illness;

(3) in psychiatry, a physician licensed under Minnesota Statutes, chapter 147, who is certified by the American Board of Psychiatry and Neurology or is eligible for board certification;

(4) in marriage and family therapy, a person licensed as a marriage and family therapist by the Minnesota Board of Marriage and Family Therapy under Minnesota Statutes, sections 148B.29 to 148B.39, and defined in parts 5300.0100 to 5300.0350;

(5) in professional counseling, a person licensed as a professional clinical counselor by the Minnesota Board of Behavioral Health and Therapy under Minnesota Statutes, section 148B.5301;

(6) a tribally approved mental health care professional, who meets the standards in Minnesota Statutes, section 256B.02, subdivision 7, paragraphs (b) and (c), and who is serving a federally recognized Indian tribe; or

(7) in psychiatric nursing, a registered nurse who is licensed under Minnesota Statutes, sections 148.171 to 148.285, and meets one of the following criteria:

(a) is certified as a clinical nurse specialist;

(b) for children, is certified as a nurse practitioner in child or adolescent or family psychiatric and mental health nursing by a national nurse certification organization; or

(c) for adults, is certified as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization.

B. A mental health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults. A mental health practitioner must be qualified in at least one of the following ways:

(1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university; and

(a) has at least 2,000 hours of supervised experience in the delivery of mental health services to clients with mental illness; or

(b) is fluent in the non-English language of the cultural group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to clients with mental illness, and receives clinical supervision from a mental health professional at least once a week until the requirements of 2,000 hours of supervised experience are met;

(2) has at least 6,000 hours of supervised experience in the delivery of mental health services to clients with mental illness. Hours worked as a mental health behavioral aide I or II under Minnesota Statutes, section 256B.0943, subdivision 7, may be included in the 6,000 hours of experience for child clients;

(3) is a graduate student in one of the mental health professional disciplines defined in item A and is formally assigned by an accredited college or university to an agency or facility for clinical training;

(4) holds a master's or other graduate degree in one of the mental health professional disciplines defined in item A from an accredited college or university; or

(5) is an individual who meets the standards in Minnesota Statutes, section 256B.02, subdivision 7, paragraphs (b) and (c), who is serving a federally recognized Indian tribe.

C. Medical assistance covers diagnostic assessment, explanation of findings, and psychotherapy performed by a mental health practitioner working as a clinical trainee when:

(1) the mental health practitioner is:

(a) complying with requirements for licensure or board certification as a mental health professional, as defined in item A, including supervised practice in the delivery of mental health services for the treatment of mental illness; or

(b) a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional defined in item A; and

(2) the mental health practitioner's clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of:

(a) direct practice;

(b) treatment team collaboration;

(c) continued professional learning; and

(d) job management.

D. A clinical supervisor must:

(1) be a mental health professional licensed as specified in item A;

(2) hold a license without restrictions that has been in good standing for at least one year while having performed at least 1,000 hours of clinical practice;

(3) be approved, certified, or in some other manner recognized as a qualified clinical supervisor by the person's professional licensing board, when this is a board requirement;

(4) be competent as demonstrated by experience and graduate-level training in the area of practice and the activities being supervised;

(5) not be the supervisee's blood or legal relative or cohabitant, or someone who has acted as the supervisee's therapist within the past two years;

(6) have experience and skills that are informed by advanced training, years of experience, and mastery of a range of competencies that demonstrate the following:

(a) capacity to provide services that incorporate best practice;

(b) ability to recognize and evaluate competencies in supervisees;

(c) ability to review assessments and treatment plans for accuracy and appropriateness;

(d) ability to give clear direction to mental health staff related to alternative strategies when a client is struggling with moving towards recovery; and

(e) ability to coach, teach, and practice skills with supervisees;

(7) accept full professional liability for a supervisee's direction of a client's mental health services;

(8) instruct a supervisee in the supervisee's work, and oversee the quality and outcome of the supervisee's work with clients;

(9) review, approve, and sign the diagnostic assessment, individual treatment plans, and treatment plan reviews of clients treated by a supervisee;

(10) review and approve the progress notes of clients treated by the supervisee according to the supervisee's supervision plan;

(11) apply evidence-based practices and research-informed models to treat clients;

(12) be employed by or under contract with the same agency as the supervisee;

(13) develop a clinical supervision plan for each supervisee;

(14) ensure that each supervisee receives the guidance and support needed to provide treatment services in areas where the supervisee practices;

(15) establish an evaluation process that identifies the performance and competence of each supervisee; and

(16) document clinical supervision of each supervisee and securely maintain the documentation record.

Subp. 6. **Release of information.** Providers who receive a request for client information and providers who request client information must:

A. comply with data practices and medical records standards in Minnesota Statutes, chapter 13, and Code of Federal Regulations, title 45, part 164; and

B. subject to the limitations in item A, promptly provide client information, including a written diagnostic assessment, to other providers who are treating the client to ensure that the client will get services without undue delay.

Subp. 7. **Individual treatment plan.** Except as provided in subpart 2, item A, subitem (1), a medical assistance payment is available only for services provided in accordance with the client's written individual treatment plan (ITP). The client must be involved in the development, review, and revision of the client's ITP. For all mental health services, except

as provided in subpart 2, item A, subitem (1), and medication management, the ITP and subsequent revisions of the ITP must be signed by the client before treatment begins. The mental health professional or practitioner shall request the client, or other person authorized by statute to consent to mental health services for the client, to sign the client's ITP or revision of the ITP. In the case of a child, the child's parent, primary caregiver, or other person authorized by statute to consent to mental health services for the child shall be asked to sign the child's ITP and revisions of the ITP. If the client or authorized person refuses to sign the plan or a revision of the plan, the mental health professional or mental health practitioner shall note on the plan the refusal to sign the plan and the reason or reasons for the refusal. A client's individual treatment plan must be:

A. based on the client's current diagnostic assessment;

B. developed by identifying the client's service needs and considering relevant cultural influences to identify planned interventions that contain specific treatment goals and measurable objectives for the client; and

C. reviewed at least once every 90 days, and revised as necessary. Revisions to the initial individual treatment plan do not require a new diagnostic assessment unless the client's mental health status has changed markedly as provided in subpart 2.

Subp. 8. **Documentation.** To obtain medical assistance payment for an outpatient mental health service, a mental health professional or a mental health practitioner must promptly document:

A. in the client's mental health record:

(1) each occurrence of service to the client including the date, type of service, start and stop time, scope of the mental health service, name and title of the person who gave the service, and date of documentation; and

(2) all diagnostic assessments and other assessments, psychological test results, treatment plans, and treatment plan reviews;

B. the provider's contact with persons interested in the client such as representatives of the courts, corrections systems, or schools, or the client's other mental health providers, case manager, family, primary caregiver, legal representative, including the name and date of the contact or, if applicable, the reason the client's family, primary caregiver, or legal representative was not contacted; and

C. dates that treatment begins and ends and reason for the discontinuation of the mental health service.

Subp. 9. **Service coordination.** The provider must coordinate client services as authorized by the client as follows:

A. When a recipient receives mental health services from more than one mental health provider, each provider must coordinate mental health services they provide to the client with other mental health service providers to ensure services are provided in the most efficient manner to achieve maximum benefit for the client.

B. The mental health provider must coordinate mental health care with the client's physical health provider.

Subp. 10. **Telemedicine services.** Mental health services in part 9505.0372 covered as direct face-to-face services may be provided via two-way interactive video if it is medically appropriate to the client's condition and needs. The interactive video equipment and connection must comply with Medicare standards that are in effect at the time of service. The commissioner may specify parameters within which mental health services can be provided via telemedicine.

**9505.0372 COVERED SERVICES.**

Subpart 1. **Diagnostic assessment.** Medical assistance covers four types of diagnostic assessments when they are provided in accordance with the requirements in this subpart.

A. To be eligible for medical assistance payment, a diagnostic assessment must:

(1) identify a mental health diagnosis and recommended mental health services, which are the factual basis to develop the recipient's mental health services and treatment plan; or

(2) include a finding that the client does not meet the criteria for a mental health disorder.

B. A standard diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The standard diagnostic assessment must be done within the cultural context of the client and must include relevant information about:

(1) the client's current life situation, including the client's:

(a) age;

(b) current living situation, including household membership and housing status;

(c) basic needs status including economic status;

(d) education level and employment status;

(e) significant personal relationships, including the client's evaluation of relationship quality;

(f) strengths and resources, including the extent and quality of social networks;

(g) belief systems;

(h) contextual nonpersonal factors contributing to the client's presenting concerns;

(i) general physical health and relationship to client's culture; and

(j) current medications;

(2) the reason for the assessment, including the client's:

(a) perceptions of the client's condition;

(b) description of symptoms, including reason for referral;

(c) history of mental health treatment, including review of the client's records;

(d) important developmental incidents;

(e) maltreatment, trauma, or abuse issues;

(f) history of alcohol and drug usage and treatment;

(g) health history and family health history, including physical, chemical, and mental health history; and

(h) cultural influences and their impact on the client;

(3) the client's mental status examination;

(4) the assessment of client's needs based on the client's baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety needs;

(5) the screenings used to determine the client's substance use, abuse, or dependency and other standardized screening instruments determined by the commissioner;

(6) assessment methods and use of standardized assessment tools by the provider as determined and periodically updated by the commissioner;

(7) the client's clinical summary, recommendations, and prioritization of needed mental health, ancillary or other services, client and family participation in assessment and service preferences, and referrals to services required by statute or rule; and

(8) the client data that is adequate to support the findings on all axes of the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association; and any differential diagnosis.

C. An extended diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The face-to-face interview is conducted over three or more assessment appointments because the client's complex needs necessitate significant additional assessment time. Complex needs are those caused by acuity of psychotic disorder; cognitive or neurocognitive impairment; need to consider past diagnoses and determine their current applicability; co-occurring substance abuse use disorder; or disruptive or changing environments, communication barriers, or cultural considerations as documented in the assessment. For child clients, the appointments may be conducted outside the diagnostician's office for face-to-face consultation and information gathering with family members, doctors, caregivers, teachers, and other providers, with or without the child present, and may involve directly observing the child in various settings that the child frequents such as home, school, or care settings. To complete the diagnostic assessment with adult clients, the appointments may be conducted outside of the diagnostician's office for face-to-face assessment with the adult client. The appointment may involve directly observing the adult client in various settings that the adult frequents, such as home, school, job, service settings, or community settings. The appointments may include face-to-face meetings with the adult client and the client's family members, doctors, caregivers, teachers, social support network members, recovery support resource representatives, and other providers for consultation and information gathering for the diagnostic assessment. The components of an extended diagnostic assessment include the following relevant information:

(1) for children under age 5:

(a) utilization of the DC:0-3R diagnostic system for young children;

(b) an early childhood mental status exam that assesses the client's developmental, social, and emotional functioning and style both within the family and with the examiner and includes:

i. physical appearance including dysmorphic features;

ii. reaction to new setting and people and adaptation during evaluation;

iii. self-regulation, including sensory regulation, unusual behaviors, activity level, attention span, and frustration tolerance;

iv. physical aspects, including motor function, muscle tone, coordination, tics, abnormal movements, and seizure activity;

v. vocalization and speech production, including expressive and receptive language;

vi. thought, including fears, nightmares, dissociative states, and hallucinations;

vii. affect and mood, including modes of expression, range, responsiveness, duration, and intensity;

viii. play, including structure, content, symbolic functioning, and modulation of aggression;

ix. cognitive functioning; and

x. relatedness to parents, other caregivers, and examiner; and

(c) other assessment tools as determined and periodically revised by the commissioner;

(2) for children ages 5 to 18, completion of other assessment standards for children as determined and periodically revised by the commissioner; and

(3) for adults, completion of other assessment standards for adults as determined and periodically revised by the commissioner.

D. A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The professional or practitioner must gather initial background information using the components of a standard diagnostic assessment in item B, subitems (1), (2), unit (b), (3), and (5), and draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem. Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.

E. Adult diagnostic assessment update includes a face-to-face interview with the client, and contains a written evaluation of the client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C, who reviews a standard or extended diagnostic assessment. The adult diagnostic assessment update must update the most recent assessment document in writing in the following areas:

(1) review of the client's life situation, including an interview with the client about the client's current life situation, and a written update of those parts where significant new or changed information exists, and documentation where there has not been significant change;

(2) review of the client's presenting problems, including an interview with the client about current presenting problems and a written update of those parts where there is significant new or changed information, and note parts where there has not been significant change;

(3) screenings for substance use, abuse, or dependency and other screenings as determined by the commissioner;

(4) the client's mental health status examination;

(5) assessment of client's needs based on the client's baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety needs;

(6) the client's clinical summary, recommendations, and prioritization of needed mental health, ancillary, or other services, client and family participation in assessment and service preferences, and referrals to services required by statute or rule; and

(7) the client's diagnosis on all axes of the current edition of the Diagnostic and Statistical Manual and any differential diagnosis.

Subp. 2. **Neuropsychological assessment.** A neuropsychological assessment must include a face-to-face interview with the client, the interpretation of the test results, and preparation and completion of a report. A client is eligible for a neuropsychological assessment if at least one of the following criteria is met:

A. There is a known or strongly suspected brain disorder based on medical history or neurological evaluation such as a history of significant head trauma, brain tumor, stroke, seizure disorder, multiple sclerosis, neurodegenerative disorders, significant exposure to neurotoxins, central nervous system infections, metabolic or toxic encephalopathy, fetal alcohol syndrome, or congenital malformations of the brain; or

B. In the absence of a medically verified brain disorder based on medical history or neurological evaluation, there are cognitive or behavioral symptoms that suggest that the client has an organic condition that cannot be readily attributed to functional psychopathology, or suspected neuropsychological impairment in addition to functional psychopathology. Examples include:

(1) poor memory or impaired problem solving;

(2) change in mental status evidenced by lethargy, confusion, or disorientation;

(3) deterioration in level of functioning;

(4) marked behavioral or personality change;

(5) in children or adolescents, significant delays in academic skill acquisition or poor attention relative to peers;

(6) in children or adolescents, significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers; and

(7) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands.

C. If neither criterion in item A nor B is fulfilled, neuropsychological evaluation is not indicated.

D. The neuropsychological assessment must be conducted by a neuropsychologist with competence in the area of neuropsychological assessment as stated to the Minnesota Board of Psychology who:

(1) was awarded a diploma by the American Board of Clinical Neuropsychology, the American Board of Professional Neuropsychology, or the American Board of Pediatric Neuropsychology;

(2) earned a doctoral degree in psychology from an accredited university training program:

(a) completed an internship, or its equivalent, in a clinically relevant area of professional psychology;

(b) completed the equivalent of two full-time years of experience and specialized training, at least one which is at the postdoctoral level, in the study and practices of clinical neuropsychology and related neurosciences supervised by a clinical neuropsychologist; and

(c) holds a current license to practice psychology independently in accordance with Minnesota Statutes, sections 148.88 to 148.98;

(3) is licensed or credentialed by another state's board of psychology examiners in the specialty of neuropsychology using requirements equivalent to requirements specified by one of the boards named in subitem (1); or

(4) was approved by the commissioner as an eligible provider of neuropsychological assessment prior to December 31, 2010.

Subp. 3. **Neuropsychological testing.**

A. Medical assistance covers neuropsychological testing when the client has either:

(1) a significant mental status change that is not a result of a metabolic disorder that has failed to respond to treatment;

(2) in children or adolescents, a significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers;

(3) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities, as required to adapt to new or changing cognitive, social, physical, or emotional demands; or

(4) a significant behavioral change, memory loss, or suspected neuropsychological impairment in addition to functional psychopathology, or other organic brain injury or one of the following:

(a) traumatic brain injury;

(b) stroke;

(c) brain tumor;

(d) substance abuse or dependence;

(e) cerebral anoxic or hypoxic episode;

(f) central nervous system infection or other infectious disease;

(g) neoplasms or vascular injury of the central nervous system;

(h) neurodegenerative disorders;

(i) demyelinating disease;

(j) extrapyramidal disease;

(k) exposure to systemic or intrathecal agents or cranial radiation known to be associated with cerebral dysfunction;

(l) systemic medical conditions known to be associated with cerebral dysfunction, including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and related hematologic anomalies, and autoimmune disorders such as lupus, erythematosis, or celiac disease;

(m) congenital genetic or metabolic disorders known to be associated with cerebral dysfunction, such as phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;

(n) severe or prolonged nutrition or malabsorption syndromes; or

(o) a condition presenting in a manner making it difficult for a clinician to distinguish between:

i. the neurocognitive effects of a neurogenic syndrome such as dementia or encephalopathy; and

ii. a major depressive disorder when adequate treatment for major depressive disorder has not resulted in improvement in neurocognitive function, or another disorder such as autism, selective mutism, anxiety disorder, or reactive attachment disorder.

B. Neuropsychological testing must be administered or clinically supervised by a neuropsychologist qualified as defined in subpart 2, item D.

C. Neuropsychological testing is not covered when performed:

(1) primarily for educational purposes;

(2) primarily for vocational counseling or training;

(3) for personnel or employment testing;

(4) as a routine battery of psychological tests given at inpatient admission or continued stay; or

(5) for legal or forensic purposes.

Subp. 4. **Psychological testing.** Psychological testing must meet the following requirements:

A. The psychological testing must:

(1) be administered or clinically supervised by a licensed psychologist with competence in the area of psychological testing as stated to the Minnesota Board of Psychology; and

(2) be validated in a face-to-face interview between the client and a licensed psychologist or a mental health practitioner working as a clinical psychology trainee as required by part 9505.0371, subpart 5, item C, under the clinical supervision of a licensed psychologist according to part 9505.0371, subpart 5, item A, subitem (2).

B. The administration, scoring, and interpretation of the psychological tests must be done under the clinical supervision of a licensed psychologist when performed by a technician, psychometrist, or psychological assistant or as part of a computer-assisted psychological testing program.

C. The report resulting from the psychological testing must be:

(1) signed by the psychologist conducting the face-to-face interview;

(2) placed in the client's record; and

(3) released to each person authorized by the client.

Subp. 5. **Explanations of findings.** To be eligible for medical assistance payment, the mental health professional providing the explanation of findings must obtain the authorization of the client or the client's representative to release the information as required in part 9505.0371, subpart 6. Explanation of findings is provided to the client, client's family, and caregivers, or to other providers to help them understand the results of the testing or diagnostic assessment, better understand the client's illness, and provide professional insight needed to carry out a plan of treatment. An explanation of findings is not paid separately when the results of psychological testing or a diagnostic assessment are explained to the client or the client's representative as part of the psychological testing or a diagnostic assessment.

Subp. 6. **Psychotherapy.** Medical assistance covers psychotherapy as conducted by a mental health professional or a mental health practitioner as defined in part 9505.0371, subpart 5, item C, as provided in this subpart.

A. Individual psychotherapy is psychotherapy designed for one client.

B. Family psychotherapy is designed for the client and one or more family members or the client's primary caregiver whose participation is necessary to accomplish the client's treatment goals. Family members or primary caregivers participating in a therapy session do not need to be eligible for medical assistance. For purposes of this subpart, the phrase "whose participation is necessary to accomplish the client's treatment goals" does not include shift or facility staff members at the client's residence. Medical assistance payment for family psychotherapy is limited to face-to-face sessions at which the client is present throughout the family psychotherapy session unless the mental health professional believes

the client's absence from the family psychotherapy session is necessary to carry out the client's individual treatment plan. If the client is excluded, the mental health professional must document the reason for and the length of time of the exclusion. The mental health professional must also document the reason or reasons why a member of the client's family is excluded.

C. Group psychotherapy is appropriate for individuals who because of the nature of their emotional, behavioral, or social dysfunctions can derive mutual benefit from treatment in a group setting. For a group of three to eight persons, one mental health professional or practitioner is required to conduct the group. For a group of nine to 12 persons, a team of at least two mental health professionals or two mental health practitioners or one mental health professional and one mental health practitioner is required to co-conduct the group. Medical assistance payment is limited to a group of no more than 12 persons.

D. A multiple-family group psychotherapy session is eligible for medical assistance payment if the psychotherapy session is designed for at least two but not more than five families. Multiple-family group psychotherapy is clearly directed toward meeting the identified treatment needs of each client as indicated in client's treatment plan. If the client is excluded, the mental health professional or practitioner must document the reason for and the length of the time of the exclusion. The mental health professional or practitioner must document the reasons why a member of the client's family is excluded.

Subp. 7. **Medication management.** The determination or evaluation of the effectiveness of a client's prescribed drug must be carried out by a physician or by an advanced practice registered nurse, as defined in Minnesota Statutes, sections 148.171 to 148.285, who is qualified in psychiatric nursing.

Subp. 8. **Adult day treatment.** Adult day treatment payment limitations include the following conditions.

A. Adult day treatment must consist of at least one hour of group psychotherapy, and must include group time focused on rehabilitative interventions, or other therapeutic services that are provided by a multidisciplinary staff. Adult day treatment is an intensive psychotherapeutic treatment. The services must stabilize the client's mental health status, and develop and improve the client's independent living and socialization skills. The goal of adult day treatment is to reduce or relieve the effects of mental illness so that an individual is able to benefit from a lower level of care and to enable the client to live and function more independently in the community. Day treatment services are not a part of inpatient or residential treatment services.

B. To be eligible for medical assistance payment, a day treatment program must:

(1) be reviewed by and approved by the commissioner;

(2) be provided to a group of clients by a multidisciplinary staff under the clinical supervision of a mental health professional;

(3) be available to the client at least two days a week for at least three consecutive hours per day. The day treatment may be longer than three hours per day, but medical assistance must not reimburse a provider for more than 15 hours per week;

(4) include group psychotherapy done by a mental health professional, or mental health practitioner qualified according to part 9505.0371, subpart 5, item C, and rehabilitative interventions done by a mental health professional or mental health practitioner daily;

(5) be included in the client's individual treatment plan as necessary and appropriate. The individual treatment plan must include attainable, measurable goals as they relate to services and must be completed before the first day treatment session. The vendor must review the recipient's progress and update the treatment plan at least every 30 days until the client is discharged and include an available discharge plan for the client in the treatment plan; and

(6) document the interventions provided and the client's response daily.

C. To be eligible for adult day treatment, a recipient must:

(1) be 18 years of age or older;

(2) not be residing in a nursing facility, hospital, institute of mental disease, or regional treatment center, unless the recipient has an active discharge plan that indicates a move to an independent living arrangement within 180 days;

(3) have a diagnosis of mental illness as determined by a diagnostic assessment;

(4) have the capacity to engage in the rehabilitative nature, the structured setting, and the therapeutic parts of psychotherapy and skills activities of a day treatment program and demonstrate measurable improvements in the recipient's functioning related to the recipient's mental illness that would result from participating in the day treatment program;

(5) have at least three areas of functional impairment as determined by a functional assessment with the domains prescribed by Minnesota Statutes, section 245.462, subdivision 11a;

(6) have a level of care determination that supports the need for the level of intensity and duration of a day treatment program; and

(7) be determined to need day treatment by a mental health professional who must deem the day treatment services medically necessary.

D. The following services are not covered by medical assistance if they are provided by a day treatment program:

(1) a service that is primarily recreation-oriented or that is provided in a setting that is not medically supervised. This includes: sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(2) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's mental illness;

(3) consultation with other providers or service agency staff about the care or progress of a client;

(4) prevention or education programs provided to the community;

(5) day treatment for recipients with primary diagnoses of alcohol or other drug abuse;

(6) day treatment provided in the client's home;

(7) psychotherapy for more than two hours daily; and

(8) participation in meal preparation and eating that is not part of a clinical treatment plan to address the client's eating disorder.

Subp. 9. **Partial hospitalization.** Partial hospitalization is a covered service when it is an appropriate alternative to inpatient hospitalization for a client who is experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission as specified in part 9505.0520, subpart 1, and who has the family and community resources necessary and appropriate to support the client's residence in the community. Partial hospitalization consists of multiple intensive short-term therapeutic services provided by a multidisciplinary staff to treat the client's mental illness.

Subp. 10. **Dialectical behavior therapy (DBT).** Dialectical behavior therapy (DBT) treatment services must meet the following criteria:

A. DBT must be provided according to this subpart and Minnesota Statutes, section 256B.0625, subdivision 5l.

B. DBT is an outpatient service that is determined to be medically necessary by either: (1) a mental health professional qualified according to part 9505.0371, subpart 5, or (2) a mental health practitioner working as a clinical trainee according to part 9505.0371, subpart 5, item C, who is under the clinical supervision of a mental health professional according to part 9505.0371, subpart 5, item D, with specialized skill in dialectical behavior therapy. The treatment recommendation must be based upon a comprehensive evaluation that includes a diagnostic assessment and functional assessment of the client, and review of the client's prior treatment history. Treatment services must be provided pursuant to the client's individual treatment plan and provided to a client who satisfies the criteria in item C.

C. To be eligible for DBT, a client must:

(1) be 18 years of age or older;

(2) have mental health needs that cannot be met with other available community-based services or that must be provided concurrently with other community-based services;

(3) meet one of the following criteria:

(a) have a diagnosis of borderline personality disorder; or

(b) have multiple mental health diagnoses and exhibit behaviors characterized by impulsivity, intentional self-harm behavior, and be at significant risk of death, morbidity, disability, or severe dysfunction across multiple life areas;

(4) understand and be cognitively capable of participating in DBT as an intensive therapy program and be able and willing to follow program policies and rules assuring safety of self and others; and

(5) be at significant risk of one or more of the following if DBT is not provided:

(a) mental health crisis;

(b) requiring a more restrictive setting such as hospitalization;

(c) decompensation; or

(d) engaging in intentional self-harm behavior.

D. The treatment components of DBT are individual therapy and group skills as follows:

(1) Individual DBT combines individualized rehabilitative and psychotherapeutic interventions to treat suicidal and other dysfunctional behaviors and reinforce the use of adaptive skillful behaviors. The therapist must:

(a) identify, prioritize, and sequence behavioral targets;

(b) treat behavioral targets;

(c) generalize DBT skills to the client's natural environment through telephone coaching outside of the treatment session;

(d) measure the client's progress toward DBT targets;

(e) help the client manage crisis and life-threatening behaviors; and

(f) help the client learn and apply effective behaviors when working with other treatment providers.

(2) Individual DBT therapy is provided by a mental health professional or a mental health practitioner working as a clinical trainee, according to part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part 9505.0371, subpart 5, item D.

(3) Group DBT skills training combines individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group format to reduce the client's suicidal and other dysfunctional coping behaviors and restore function by teaching the client adaptive skills in the following areas:

(a) mindfulness;

(b) interpersonal effectiveness;

(c) emotional regulation; and

(d) distress tolerance.

(4) Group DBT skills training is provided by two mental health professionals, or by a mental health professional cofacilitating with a mental health practitioner.

(5) The need for individual DBT skills training must be determined by a mental health professional or a mental health practitioner working as a clinical trainee, according to part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part 9505.0371, subpart 5, item D.

E. A program must be certified by the commissioner as a DBT provider. To qualify for certification, a provider must:

(1) hold current accreditation as a DBT program from a nationally recognized certification body approved by the commissioner or submit to the commissioner's inspection and provide evidence that the DBT program's policies, procedures, and practices will continuously meet the requirements of this subpart;

(2) be enrolled as a MHCP provider;

(3) collect and report client outcomes as specified by the commissioner; and

(4) have a manual that outlines the DBT program's policies, procedures, and practices which meet the requirements of this subpart.

F. The DBT treatment team must consist of persons who are trained in DBT treatment. The DBT treatment team may include persons from more than one agency. Professional and clinical affiliations with the DBT team must be delineated:

(1) A DBT team leader must:

(a) be a mental health professional employed by, affiliated with, or contracted by a DBT program certified by the commissioner;

(b) have appropriate competencies and working knowledge of the DBT principles and practices; and

(c) have knowledge of and ability to apply the principles and DBT practices that are consistent with evidence-based practices.

(2) DBT team members who provide individual DBT or group skills training must:

(a) be a mental health professional or be a mental health practitioner, who is employed by, affiliated with, or contracted with a DBT program certified by the commissioner;

(b) have or obtain appropriate competencies and working knowledge of DBT principles and practices within the first six months of becoming a part of the DBT program;

(c) have or obtain knowledge of and ability to apply the principles and practices of DBT consistently with evidence-based practices within the first six months of working at the DBT program;

(d) participate in DBT consultation team meetings; and

(e) require mental health practitioners to have ongoing clinical supervision by a mental health professional who has appropriate competencies and working knowledge of DBT principles and practices.

Subp. 11. **Noncovered services.** The mental health services in items A to J are not eligible for medical assistance payment under this part:

A. a mental health service that is not medically necessary;

B. a neuropsychological assessment carried out by a person other than a neuropsychologist who is qualified according to part 9505.0372, subpart 2, item D;

C. a service ordered by a court that is solely for legal purposes and not related to the recipient's diagnosis or treatment for mental illness;

D. services dealing with external, social, or environmental factors that do not directly address the recipient's physical or mental health;

E. a service that is only for a vocational purpose or an educational purpose that is not mental health related;

F. staff training that is not related to a client's individual treatment plan or plan of care;

G. child and adult protection services;

H. fund-raising activities;

I. community planning; and

J. client transportation.

## 9520.0010 STATUTORY AUTHORITY AND PURPOSE.

Parts 9520.0010 to 9520.0230 provide methods and procedures relating to the establishment and operation of area-wide, comprehensive, community-based mental health, developmental disability, and chemical dependency programs under state grant-in-aid as provided under Minnesota Statutes, sections 245.61 to 245.69. Minnesota Statutes, sections 245.61 to 245.69 are entitled The Community Mental Health Services Act. For purposes of these parts, "community mental health services" includes services to persons who have mental or emotional disorders or other psychiatric disabilities, developmental disabilities, and chemical dependency, including drug abuse and alcoholism.

## 9520.0020 BOARD DUTIES.

The community mental health board has the responsibility for ensuring the planning, development, implementation, coordination, and evaluation of the community comprehensive mental health program for the mentally ill/behaviorally disabled, developmentally disabled, and chemically dependent populations in the geographic area it serves. It also has the responsibility for ensuring delivery of services designated by statute.

## 9520.0030 DEFINITIONS.

Parts 9520.0040 and 9520.0050 also set forth definitions of community mental health centers and community mental health clinics.

## 9520.0040 COMMUNITY MENTAL HEALTH CENTER.

A community mental health center means an agency which includes all of the following:

A. Established under the provision of Minnesota Statutes, sections 245.61 to 245.69.

B. Provides as a minimum the following services for individuals with mental or emotional disorders, developmental disabilities, alcoholism, drug abuse, and other psychiatric conditions. The extent of each service to be provided by the center shall be indicated in the program plan, which is to reflect the problems, needs, and resources of the community served:

(1) collaborative and cooperative services with public health and other groups for programs of prevention of mental illness, developmental disability, alcoholism, drug abuse, and other psychiatric disorders;

(2) informational and educational services to schools, courts, health and welfare agencies, both public and private;

(3) informational and educational services to the general public, lay, and professional groups;

(4) consultative services to schools, courts, and health and welfare agencies, both public and private;

(5) outpatient diagnostic and treatment services; and

(6) rehabilitative services, particularly for those who have received prior treatment in an inpatient facility.

C. Provides or contracts for detoxification, evaluation, and referral for chemical dependency services (Minnesota Statutes, section 254A.08).

D. Provides specific coordination for mentally ill/behaviorally disabled, developmental disability, and chemical dependency programs. (Minnesota Statutes, sections 254A.07 and 245.61).

E. Has a competent multidisciplinary mental health/developmental disability/chemical dependency professional team whose members meet the professional standards in their respective fields.

F. The professional mental health team is qualified by specific mental health training and experience and shall include as a minimum the services of each of the following:

(1) a licensed physician, who has completed an approved residency program in psychiatry; and

(2) a doctoral clinical, counseling, or health care psychologist, who is licensed under Minnesota Statutes, sections 148.88 to 148.98; and one or both of the following:

(3) a clinical social worker with a master's degree in social work from an accredited college or university; and/or

(4) a clinical psychiatric nurse with a master's degree from an accredited college or university and is registered under Minnesota Statutes, section 148.171. The master's degree shall be in psychiatric nursing or a related psychiatric nursing program such as public health nursing with mental health major, maternal and child health with mental health major, etc.

G. The multidisciplinary staff shall be sufficient in number to implement and operate the described program of the center. In addition to the above, this team should include other professionals, paraprofessionals, and disciplines, particularly in the preventive and rehabilitative components of the program, subject to review and approval of job descriptions and qualifications by the commissioner. If any of the minimum required professional staff are not immediately available, the commissioner may approve and make grants for the operation of the center, provided that the board and director can show evidence acceptable to the commissioner that they are making sincere, reasonable, and ongoing efforts

to acquire such staff and show evidence of how the specialized functions of the required professionals are being met. The services being rendered by employed personnel shall be consistent with their professional discipline.

**9520.0050 COMMUNITY MENTAL HEALTH CLINIC.**

Subpart 1. **Definitions.** A community mental health clinic is an agency which devotes, as its major service, at least two-thirds of its resources for outpatient mental health diagnosis, treatment, and consultation by a multidisciplinary professional mental health team. The multidisciplinary professional mental health team is qualified by special mental health training and experience and shall include as a minimum the services of each of the following:

A. a licensed physician, who has completed an approved residency program in psychiatry; and

B. a doctoral clinical, or counseling or health care psychologist who is licensed under Minnesota Statutes, sections 148.88 to 148.98; and one or both of the following:

C. a clinical social worker with a master's degree in social work from an accredited college or university; and/or

D. a clinical psychiatric nurse with a master's degree from an accredited college or university and is registered under Minnesota Statutes, section 148.171. The master's degree shall be in psychiatric nursing or a related psychiatric nursing program such as public health with a mental health major, maternal and child health with a mental health major.

Subp. 2. **Other members of multidisciplinary team.** The multidisciplinary team shall be sufficient in number to implement and operate the described program of the clinic. In addition to the above, this team should include other professionals, paraprofessionals and disciplines, particularly in the preventive and rehabilitative components of the program, subject to review and approval of job descriptions and qualifications by the commissioner.

Subp. 3. **Efforts to acquire staff.** If any of the minimum required professional staff are not immediately available, the commissioner may approve and make grants for the operation of the clinic, provided that the board and director can show evidence acceptable to the commissioner that they are making sincere, reasonable, and ongoing efforts to acquire such staff and evidence of how the specialized functions of the required professional positions are being met. The services being rendered by employed personnel shall be consistent with their professional discipline.

**9520.0060 ANNUAL PLAN AND BUDGET.**

On or before the date designated by the commissioner, each year the chair of the community mental health board or director of the community mental health program, provided for in Minnesota Statutes, section 245.62, shall submit an annual plan identifying program priorities in accordance with state grant-in-aid guidelines, and a budget on prescribed report forms for the next state fiscal year, together with the recommendations of the community mental health board, to the commissioner of human services for approval as provided under Minnesota Statutes, section 245.63.

**9520.0070 FISCAL AFFILIATES.**

Other providers of community mental health services may affiliate with the community mental health center and may be approved and eligible for state grant-in-aid funds. The state funding for other community mental health services shall be contingent upon appropriate inclusion in the center's community mental health plan for the continuum of community mental health services and conformity with the state's appropriate disability plan for mental health, developmental disability, or chemical dependency. Fiscal affiliates (funded contracting agencies) providing specialized services under contract must meet all rules and standards that apply to the services they are providing.

**9520.0080 OTHER REQUIRED REPORTS.**

The program director of the community mental health program shall provide the commissioner of human services with such reports of program activities as the commissioner may require.

**9520.0090 FUNDING.**

All state community mental health funding shall go directly to the community mental health board or to a human service board established pursuant to Laws of Minnesota 1975, chapter 402, which itself provides or contracts with another agency to provide the community mental health program. Such programs must meet the standards and rules for community mental health programs as enunciated in parts 9520.0010 to 9520.0230 in accordance with Laws of Minnesota 1975, chapter 402.

**9520.0100 OPERATION OF OTHER PROGRAMS.**

When the governing authority of the community mental health program operates other programs, services, or activities, only the community mental health center program shall be subject to these parts.

**9520.0110 APPLICATIONS AND AGREEMENTS BY LOCAL COUNTIES.**

New applications for state assistance or applications for renewal of support must be accompanied by an agreement executed by designated signatories on behalf of the participating counties that specifies the involved counties, the amount and source of local funds in each case, and the period of support. The local funds to be used to match state grant-in-aid must be assured in writing on Department of Human Services forms by the local funding authority(ies).

**9520.0120 USE OF MATCHING FUNDS.**

Funds utilized by the director as authorized by the community mental health board to match a state grant-in-aid must be available to that director for expenditures for the same general purpose as the state grant-in-aid funds.

**9520.0130 QUARTERLY REPORTS.**

The director of the community mental health program shall, within 20 days after the end of the quarter, submit quarterly prescribed reports to the commissioner of human services (controller's office), containing all receipts, expenditures, and cash balance, subject to an annual audit by the commissioner or his/her designee.

**9520.0140 PAYMENTS.**

Payments on approved grants will be made subsequent to the department's receipt of the program's quarterly reporting forms, unless the commissioner of human services has determined that funds allocated to a program are not needed for that program. Payments shall be in an amount of at least equal to the quarterly allocation minus any unexpended balance from the previous quarter providing this payment does not exceed the program grant award. In the event the program does not report within the prescribed time, the department will withhold the process of the program's payment until the next quarterly cycle.

**9520.0150 FEES.**

No fees shall be charged until the director with approval of the community mental health board has established fee schedules for the services rendered and they have been submitted to the commissioner of human services at least two months prior to the effective date thereof and have been approved by him/her. All fees shall conform to the approved schedules, which are accessible to the public.

**9520.0160 SUPPLEMENTAL AWARDS.**

The commissioner of human services may make supplemental awards to the community mental health boards.

**9520.0170 WITHDRAWAL OF FUNDS.**

The commissioner of human services may withdraw funds from any program that is not administered in accordance with its approved plan and budget. Written notice of such intended action will be provided to the director and community mental health board. Opportunity for hearing before the commissioner or his/her designee shall be provided.

**9520.0180 BUDGET TRANSFERS.**

Community mental health boards may make budget transfers within specified limits during any fiscal year without prior approval of the department. The specified limit which can be transferred in any fiscal year between program activity budgets shall be up to ten percent or up to $5,000 whichever is less. Transfers within an activity can be made into or out of line items with a specified limit of up to ten percent or up to $5,000 whichever is less. No line item can be increased or decreased by more than $5,000 or ten percent in a fiscal year without prior approval of the commissioner. Transfers above the specified limits can be made with prior approval from the commissioner. All transfers within and into program budget activities and/or line items must have prior approval by the community mental health board and this approval must be reflected in the minutes of its meeting, it must be reported to the commissioner with the reasons therefor, including a statement of how the transfer will affect program objectives.

**9520.0190 BUDGET ADJUSTMENTS.**

Budget adjustments made necessary by funding limitations shall be made by the commissioner and provided in writing to the director and board of the community mental health center.

**9520.0200 CENTER DIRECTOR.**

Every community mental health board receiving state funds for a community mental health program shall have a center director, who is the full-time qualified professional staff member who serves as the executive officer. To be considered qualified, the individual must have professional training to at least the level of graduate degree in his/her clinical and/or administrative discipline, which is relevant to MH-DD-CD and a minimum of two years experience in community mental health programs. The center director is responsible for the planning/design, development, coordination, and evaluation of a comprehensive, area-wide program and for the overall administration of services operated by the board.

The center director shall be appointed by the community mental health board and shall be approved by the commissioner of human services.

**9520.0210 DEADLINE FOR APPROVAL OR DENIAL OF REQUEST FOR APPROVAL STATUS.**

The commissioner shall approve or deny, in whole or in part, an application for state financial assistance within 90 days of receipt of the grant-in-aid application or by the beginning of the state fiscal year, whichever is the later.

**9520.0230 ADVISORY COMMITTEE.**

Subpart 1. **Purpose.** To assist the community mental health board in meeting its responsibilities as described in Minnesota Statutes, section 245.68 and to provide opportunity for broad community representation necessary for effective comprehensive mental health, developmental disability, and chemical dependency program planning, each community

mental health board shall appoint a separate advisory committee in at least the three disability areas of mental health, developmental disability, and chemical dependency.

Subp. 2. **Membership.** The advisory committees shall consist of residents of the geographic area served who are interested and knowledgeable in the area governed by such committee.

Subp. 3. **Nominations for membership.** Nominations for appointments as members of the advisory committees are to be made to the community mental health board from agencies, organizations, groups, and individuals within the area served by the community mental health center. Appointments to the advisory committees are made by the community mental health board.

Subp. 4. **Board member on committee.** One community mental health board member shall serve on each advisory committee.

Subp. 5. **Nonprovider members.** Each advisory committee shall have at least one-half of its membership composed of individuals who are not providers of services to the three disability groups.

Subp. 6. **Representative membership.** Membership of each advisory committee shall generally reflect the population distribution of the service delivery area of the community mental health center.

Subp. 7. **Chairperson appointed.** The community mental health board shall appoint a chairperson for each advisory committee. The chairperson shall not be a community mental health board member nor a staff member. The power to appoint the chairperson may be delegated by the community mental health board to the individual advisory committee.

Subp. 8. **Committee responsibility to board.** Each advisory committee shall be directly responsible to the community mental health board. Direct communication shall be effected and maintained through contact between the chairperson of the particular advisory committee, or his/her designee, and the chairperson of the community mental health board, or his/her designee.

Subp. 9. **Staff.** Staff shall be assigned by the director to serve the staffing needs of each advisory committee.

Subp. 10. **Study groups and task forces.** Each advisory committee may appoint study groups and task forces upon consultation with the community mental health board. It is strongly recommended that specific attention be given to the aging and children and youth populations.

Subp. 11. **Quarterly meetings required.** Each advisory committee shall meet at least quarterly.

Subp. 12. **Annual report required.** Each advisory committee must make a formal written and oral report on its work to the community mental health board at least annually.

Subp. 13. **Minutes.** Each advisory committee shall submit copies of minutes of their meetings to the community mental health board and to the Department of Human Services (respective disability group program divisions).

Subp. 14. **Duties of advisory committee.** The advisory committees shall be charged by the community mental health board with assisting in the identification of the community's needs for mentally ill/behaviorally disabled, developmental disability, and chemical dependency programs. The advisory committee also assists the community mental health board in determining priorities for the community programs. Based on the priorities, each advisory committee shall recommend to the community mental health board ways in which the limited available community resources (work force, facilities, and finances) can be put to maximum and optimal use.

Subp. 15. **Recommendations.** The advisory committee recommendations made to the community mental health board shall be included as a separate section in the grant-in-aid request submitted to the Department of Human Services by the community mental health board.

Subp. 16. **Assessment of programs.** The advisory committees shall assist the community mental health board in assessing the programs carried on by the community mental health board, and make recommendations regarding the reordering of priorities and modifying of programs where necessary.

## 9549.0057 DETERMINATION OF INTERIM AND SETTLE UP OPERATING COST PAYMENT RATES.

Subpart 1. **Conditions.** To receive an interim payment rate, a nursing facility must comply with the requirements and is subject to the conditions in part 9549.0060, subpart 14, items A to C. The commissioner shall determine interim and settle up operating cost payment rates for a newly constructed nursing facility, or one with an increase in licensed capacity of 50 percent or more according to subparts 2 and 3.

Subp. 2. **Interim operating cost payment rate.** For the rate year or portion of an interim period beginning on or after July 1, 1986, the interim total operating cost payment rate must be determined according to parts 9549.0050 to 9549.0059 (Temporary) in effect on March 1, 1987. For the rate year or portion of an interim period beginning on or after July 1, 1987, the interim total operating cost payment rate must be determined according to parts 9549.0051 to 9549.0059, except that:

A. The nursing facility must project its anticipated resident days for each resident class. The anticipated resident days for each resident class must be multiplied by the weight for that resident class as listed in part 9549.0058 to determine the anticipated standardized resident days for the reporting period.

B. The commissioner shall use anticipated standardized resident days in determining the allowable historical case mix operating cost standardized per diem.

C. The commissioner shall use the anticipated resident days in determining both the allowable historical other care related operating cost per diem and the allowable historical other operating cost per diem.

D. The annual adjustment factors determined in part 9549.0055, subpart 1, must not be applied to the nursing facility's allowable historical per diems as provided in part 9549.0056, subparts 2 and 4.

E. The limits established in part 9549.0055, subpart 2, items C and E, as indexed in part 9549.0055, subpart 3 and in effect at the beginning of the interim period, must be increased by ten percent.

F. The efficiency incentive in part 9549.0056, subpart 4, item A or B, must not apply.

G. The phase in provisions in part 9549.0056, subpart 7, must not apply.

Subp. 3. **Settle up operating cost payment rate.** The settle up total operating cost payment rate must be determined according to items A to C.

A. The settle up operating cost payment rate for interim periods before July 1, 1987, is subject to the rule parts that were in effect during the interim period.

B. To determine the settle up operating cost payment rate for interim periods or the portion of an interim period occurring after July 1, 1987, subitems (1) to (7) must be applied.

(1) The standardized resident days as determined in part 9549.0054, subpart 2, must be used for the interim period.

(2) The commissioner shall use the standardized resident days in subitem (1) in determining the allowable historical case mix operating cost standardized per diem.

(3) The commissioner shall use the actual resident days in determining both the allowable historical other care related operating cost per diem and the allowable historical other operating cost per diem.

(4) The annual adjustment factors determined in part 9549.0055, subpart 1, must not be applied to the nursing facility's allowable historical per diems as provided in part 9549.0056, subparts 2 and 4.

(5) The limits established in part 9549.0055, subpart 2, item E, must be the limits for the settle up reporting periods occurring after July 1, 1987. If the interim period includes more than one July 1 date, the commissioner shall use the limit established in part 9549.0055, subpart 2, items C and E, as indexed in part 9549.0055, subpart 3, increased by ten percent for the second July 1 date.

(6) The efficiency incentive in part 9549.0056, subpart 4, item A or B, must not apply.

(7) The phase in provisions in part 9549.0056, subpart 7 must not apply.

C. For the nine month period following the settle up reporting period, the total operating cost payment rate must be determined according to item B except that the efficiency incentive as computed in part 9549.0056, subpart 4, item A or B, applies.

D. The total operating cost payment rate for the rate year beginning July 1 following the nine month period in item C must be determined under parts 9549.0050 to 9549.0059.

E. A newly constructed nursing facility or one with an increase in licensed capacity of 50 percent or more must continue to receive the interim total operating cost payment rate until the settle up total operating cost payment rate is determined under this subpart.

**9549.0060 DETERMINATION OF THE PROPERTY-RELATED PAYMENT RATE.**

Subp. 4. **Determination of allowable appraised value.** A nursing facility's appraised value must be limited by items A to C.

A. For rate years beginning after June 30, 1985, the replacement cost new per bed limit for licensed beds in single bedrooms and multiple bedrooms is determined according to subitems (1) to (4):

(1) Effective January 1, 1984, the replacement cost new per bed limit for licensed beds in single bedrooms is $41,251 and for licensed beds in multiple bedrooms is $27,500. On January 1, 1985, the commissioner shall adjust the replacement cost new per bed limit by the percentage change in the composite cost of construction index published by the Bureau of Economic Analysis of the United States Department of Commerce in the Survey of Current Business Statistics for the two previous Octobers. The index is incorporated by reference and is available at the James J. Hill Reference Library, Saint Paul, Minnesota.

(2) The average historical cost per bed for depreciable equipment is computed by adding the historical cost of depreciable equipment for each nursing facility as determined in subpart 10, item A, and dividing the sum by the total number of licensed beds in those nursing facilities. The amount is then subtracted from the replacement cost new per bed limits determined in subitem (1).

(3) The differences computed in subitem (2) are the replacement cost new per bed limits for licensed beds in single bedrooms and multiple bedrooms effective for the rate year beginning on July 1, 1985.

(4) On January 1, 1986, and each succeeding January 1, the commissioner shall adjust the limit in subitem (3) by the percentage change in the composite cost of

construction index published by the Bureau of Economic Analysis of the United States Department of Commerce in the Survey of Current Business Statistics for the two previous Octobers.

B. Each nursing facility's maximum allowable replacement cost new is determined annually according to subitems (1) to (3):

(1) The multiple bedroom replacement cost new per bed limit in item A must be multiplied by the number of licensed beds in multiple bedrooms.

(2) The single bedroom replacement cost new per bed limit in item A must be multiplied by the number of licensed beds in single bedrooms except as provided in subpart 11, item C, subitem (2).

(3) The nursing facility's maximum allowable replacement cost new is the sum of subitems (1) and (2).

C. The nursing facility's replacement cost new determined in subparts 1 to 3 must be reduced by the replacement cost new of portions of the nursing facility used for functions whose costs are disallowed under parts 9549.0010 to 9549.0080.

D. The adjusted replacement cost new is the lesser of item B or C.

E. The adjusted depreciation is determined by subtracting from the depreciation in subparts 1 to 3 the amount of depreciation, if any, related to the portion of the nursing facility's replacement cost new disallowed in item C or D.

F. The nursing facility's allowable appraised value is determined by subtracting the amount determined in item E from the amount in item D. If no adjustment to the replacement cost new is required in items C and D, then the nursing facility's allowable appraised value is the appraised value determined in subparts 1 to 3.

Subp. 5. **Allowable debt.** For purposes of determining the property-related payment rate, the commissioner shall allow or disallow debt according to items A to D.

A. Debt shall be limited as follows:

(1) Debt incurred for the purchase of land directly used for resident care and the purchase or construction of nursing facility buildings, attached fixtures, or land improvements or the capitalized replacement or capitalized repair of existing buildings, attached fixtures, or land improvements shall be allowed. Debt incurred for any other purpose shall not be allowed.

(2) Working capital debt shall not be allowed.

(3) An increase in the amount of a debt as a result of refinancing of capital assets which occurs after May 22, 1983, shall not be allowed except to the extent that the increase in debt is the result of refinancing costs such as points, loan origination fees, or title searches.

(4) An increase in the amount of total outstanding debt incurred after May 22, 1983, as a result of a change in ownership or reorganization of provider entities, shall not be allowed and the previous owner's allowable debt as of May 22, 1983, shall be allowed under item B.

(5) Any portion of the total allowable debt exceeding the appraised value as determined in subpart 4 shall not be allowed.

(6) Any portion of a debt of which the proceeds exceed the historical cost of the capital asset acquired shall not be allowed.

B. The nursing facility shall apportion debts incurred before October 1, 1984, among land and buildings, attached fixtures, land improvements, depreciable equipment and working capital by direct identification. If direct identification of any part of the debt is not possible, that portion of the debt which cannot be directly identified shall be

apportioned to each component, except working capital debt, based on the ratio of the historical cost of the component to the total historical cost of all components. The portion of debt assigned to land and buildings, attached fixtures, and land improvements is allowable debt.

A hospital attached nursing facility that has debts that are not directly identifiable to the hospital or the nursing facility shall allocate the portion of allowable debt computed according to subpart 5, and allowable interest expense computed according to subpart 7 assigned to land and buildings, attached fixtures, and land improvements using the Medicare stepdown method described in subpart 1.

C. For debts incurred after September 30, 1984, the nursing facility shall directly identify the proceeds of the debt associated with specific land and buildings, attached fixtures, and land improvements, and keep records that separate such debt proceeds from all other debt. Only the debt identified with specific land and buildings, attached fixtures, and land improvement shall be allowed.

D. For reporting years ending on or after September 30, 1984, the total amount of allowable debt shall be the sum of all allowable debts at the beginning of the reporting year plus all allowable debts at the end of the reporting year divided by two. Nursing facilities which have a debt with a zero balance at the beginning or end of the reporting year must use a monthly average for the reporting year.

E. Debt incurred as a result of loans between related organizations must not be allowed.

Subp. 6. **Limitations on interest rates.** The commissioner shall limit interest rates according to items A to C.

A. Except as provided in item B, the effective interest rate of each allowable debt, including points, financing charges, and amortization bond premiums or discounts, entered into after September 30, 1984, is limited to the lesser of:

(1) the effective interest rate on the debt; or

(2) 16 percent.

B. Variable or adjustable rates for allowable debt are allowed subject to item A. For each allowable debt with a variable or adjustable rate, the effective interest rate must be computed by dividing the interest expense for the reporting year by the average allowable debt computed under subpart 5, item D.

C. For rate years beginning on July 1, 1985, and July 1, 1986, the effective interest rate for debts incurred before October 1, 1984, is allowed if the interest rate is not in excess of what the borrower would have had to pay in an arms length transaction in the market in which the debt was incurred. For rate years beginning after June 30, 1987, the effective interest rate for debts incurred before October 1, 1984, is allowed subject to item A.

Subp. 7. **Allowable interest expense.** The commissioner shall allow or disallow interest expense including points, finance charges, and amortization bond premiums or discounts under items A to G.

A. Interest expense is allowed only on the debt which is allowed under subpart 5 and within the interest rate limits in subpart 6.

B. A nonprofit nursing facility shall use its restricted funds to purchase or replace capital assets to the extent of the cost of those capital assets before it borrows funds for the purchase or replacement of those capital assets. For purposes of this item and part 9549.0035, subpart 2, a restricted fund is a fund for which use is restricted to the purchase or replacement of capital assets by the donor or by the nonprofit nursing facility's board.

C. Construction period interest expense must be capitalized as a part of the cost of the building. The period of construction extends to the earlier of either the first day a

resident is admitted to the nursing facility, or the date the nursing facility is certified to receive medical assistance recipients.

D. Interest expense for allowable debts entered into after May 22, 1983, is allowed for the portion of the debt which together with all outstanding allowable debt does not exceed 100 percent of the most recent allowable appraised value as determined in subparts 1 to 4.

E. Increases in interest expense after May 22, 1983, which are the result of changes in ownership or reorganization of provider entities, are not allowable.

F. Except as provided in item G, increases in total interest expense which are the result of refinancing of debt after May 22, 1983, are not allowed. The total interest expense must be computed as the sum of the annual interest expense over the remaining term of the debt refinanced.

G. Increases in total interest expense which result from refinancing a balloon payment on allowable debt after May 22, 1983, shall be allowed according to subitems (1) to (3).

(1) The interest rate on the refinanced debt shall be limited under subpart 6, item A.

(2) The refinanced debt shall not exceed the balloon payment.

(3) The term of the refinanced debt must not exceed the term of the original debt computed as though the balloon payment did not exist.

Subp. 10. **Equipment allowance.** For rate years beginning after June 30, 1985, the equipment allowance must be computed according to items A to E.

A. The historical cost of depreciable equipment for nursing facilities which do not have costs for operating leases for depreciable equipment in excess of $10,000 during the reporting year ending September 30, 1984, is determined under subitem (1) or (2).

(1) The total historical cost of depreciable equipment reported on the nursing facility's audited financial statement for the reporting year ending September 30, 1984, must be multiplied by 70 percent. The product is the historical cost of depreciable equipment.

(2) The nursing facility may submit an analysis which classifies the historical cost of each item of depreciable equipment reported on September 30, 1984. The analysis must include an itemized description of each piece of depreciable equipment and its historical cost. The sum of the historical cost of each piece of equipment is the total historical cost of depreciable equipment for that nursing facility.

For purposes of this item, a hospital attached nursing facility shall use the allocation method in subpart 1 to stepdown the historical cost of depreciable equipment.

B. The historical cost per bed of depreciable equipment for each nursing facility must be computed by dividing the total historical cost of depreciable equipment determined in item A by the nursing facility's total number of licensed beds on September 30, 1984.

C. All nursing facilities must be grouped in one of the following:

(1) nursing facilities with total licensed beds of less than 61 beds;

(2) nursing facilities with total licensed beds of more than 60 beds and less than 101 beds; or

(3) nursing facilities with more than 100 total licensed beds.

D. Within each group determined in item C, the historical cost per bed for each nursing facility determined in item B must be ranked and the median historical cost per bed established.

E. The median historical cost per bed for each group in item C as determined in item D must be increased by ten percent. For rate years beginning after June 30, 1986, this

amount shall be adjusted annually by the percentage change indicated by the urban consumer price index for Minneapolis-Saint Paul, as published by the Bureau of Labor Statistics, new series index (1967=100) for the two previous Decembers. This index is incorporated by reference and available at the James J. Hill Reference Library, Saint Paul, Minnesota.

F. The equipment allowance for each group in item C shall be the amount computed in item E multiplied by 15 percent and divided by 350.

Subp. 11. **Capacity days.** The number of capacity days is determined under items A to C.

A. The number of capacity days is determined by multiplying the number of licensed beds in the nursing facility by the number of days in the nursing facility's reporting period.

B. Except as in item C, nursing facilities shall increase the number of capacity days by multiplying the number of licensed single bedrooms by 0.5 and by the number of days in the nursing facility's reporting period.

C. The commissioner shall waive the requirements of item B if a nursing facility agrees in writing to subitems (1) to (3).

(1) The nursing facility shall agree not to request a private room payment in part 9549.0070, subpart 3 for any of its medical assistance residents in licensed single bedrooms.

(2) The nursing facility shall agree not to use the single bedroom replacement cost new limit for any of its licensed single bedrooms in the computation of the allowable appraised value in subpart 4.

(3) The nursing facility shall agree not to charge any private paying resident in a single bedroom a payment rate that exceeds the amount calculated under units (a) to (c).

(a) The nursing facility's average total payment rate shall be determined by multiplying the total payment rate for each case mix resident class by the number of resident days for that class in the nursing facility's reporting year and dividing the sum of the resident class amounts by the total number of resident days in the nursing facility's reporting year.

(b) The nursing facility's maximum single bedroom adjustment must be determined by multiplying its average total payment rate calculated under unit (a) by ten percent.

(c) The nursing facility's single bedroom adjustment which must not exceed the amount computed in unit (b) must be added to each total payment rate established in Minnesota Statutes, sections 256B.431, 256B.434, and 256B.441, to determine the nursing facility's single bedroom payment rates.

Subp. 14. **Determination of interim and settle-up payment rates.** The commissioner shall determine interim and settle-up payment rates according to items A to J.

A. A newly constructed nursing facility, or one with a capacity increase of 50 percent or more, may submit a written application to the commissioner to receive an interim payment rate. The nursing facility shall submit cost reports and other supporting information as required in parts 9549.0010 to 9549.0080 for the reporting year in which the nursing facility plans to begin operation at least 60 days before the first day a resident is admitted to the newly constructed nursing facility bed. The nursing facility shall state the reasons for noncompliance with parts 9549.0010 to 9549.0080. The effective date of the interim payment rate is the earlier of either the first day a resident is admitted to the newly constructed nursing facility or the date the nursing facility bed is certified for medical assistance. The interim payment rate for a newly constructed nursing facility, or a nursing facility with a capacity increase of 50 percent or more, is determined under items B to D.

B. The interim payment rate must not be in effect more than 17 months. When the interim payment rate begins between May 1 and September 30, the nursing facility shall file settle-up cost reports for the period from the beginning of the interim payment rate through September 30 of the following year. When the interim payment rate begins between October 1 and April 30, the nursing facility shall file settle-up cost reports for the period from the beginning of the interim payment rate to the first September 30 following the beginning of the interim payment rate.

C. The interim payment rate for a nursing facility which commenced construction prior to July 1, 1985, is determined by 12 MCAR S 2.05014 [Temporary] except that capital assets must be classified under parts 9549.0010 to 9549.0080.

D. The interim property-related payment rate for a nursing facility which commences construction after June 30, 1985, is determined as follows:

(1) At least 60 days before the first day a resident is admitted to the newly constructed nursing facility bed and upon receipt of written application from the nursing facility, the commissioner shall establish the nursing facility's appraised value according to subparts 1 and 4.

(2) The nursing facility shall project the allowable debt and the allowable interest expense according to subparts 5 and 7.

(3) The interim building capital allowance must be determined under subpart 8 or 9.

(4) The equipment allowance during the interim period must be the equipment allowance computed in accordance with subpart 10 which is in effect on the effective date of the interim property-related payment rate.

(5) The interim property-related payment rate must be the sum of subitems (3) and (4).

(6) Anticipated resident days may be used instead of 96 percent capacity days.

E. The settle-up property-related payment rate and the property-related payment rate for the nine months following the settle up for a nursing facility which commenced construction before July 1, 1985, is determined under 12 MCAR S 2.05014 [Temporary]. The property-related payment rate for the rate year beginning July 1 following the nine month period is determined under part 9549.0060.

F. The settle-up property-related payment rate for a nursing facility which commenced construction after June 30, 1985, shall be established as follows:

(1) The appraised value determined in item D, subitem (1), must be updated in accordance with subpart 2, item B prorated for each rate year, or portion of a rate year, included in the interim payment rate period.

(2) The nursing facility's allowable debt, allowable interest rate, and allowable interest expense for the interim rate period shall be computed in accordance with subparts 5, 6, and 7.

(3) The settle-up building capital allowance shall be determined in accordance with subpart 8 or 9.

(4) The equipment allowance shall be updated in accordance with subpart 10 prorated for each rate year, or portion of a rate year, included in the interim payment rate period.

(5) The settle-up property-related payment rate must be the sum of subitems (3) and (4).

(6) Resident days may be used instead of 96 percent capacity days.

G. The property-related payment rate for the nine months following the settle up for a nursing facility which commenced construction after June 30, 1985, shall be established in accordance with item F except that 96 percent capacity days must be used.

H. The property-related payment rate for the rate year beginning July 1 following the nine month period in item G must be determined under this part.

I. A newly constructed nursing facility or one with a capacity increase of 50 percent or more must continue to receive the interim property-related payment rate until the settle-up property-related payment rate is determined under this subpart.

J. The interim real estate taxes and special assessments payment rate shall be established using the projected real estate taxes and special assessments cost divided by anticipated resident days. The settle-up real estate taxes and special assessments payment rate shall be established using the real estate taxes and special assessments divided by resident days. The real estate and special assessments payment rate for the nine months following the settle up shall be equal to the settle-up real estate taxes and special assessments payment rate.