

**SENATE**  
**STATE OF MINNESOTA**  
**EIGHTY-NINTH SESSION**

**S.F. No. 1458**

**(SENATE AUTHORS: LOUREY)**

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

A bill for an act

1.1 relating to state government; establishing the health and human services budget;  
1.2 modifying provisions governing children and family services, chemical and  
1.3 mental health services, withdrawal management programs, direct care and  
1.4 treatment, health care, continuing care, Department of Health programs,  
1.5 health care delivery, health licensing boards, and MNsure; making changes  
1.6 to medical assistance, general assistance, MFIP, Northstar Care for Children,  
1.7 MinnesotaCare, child care assistance, and group residential housing programs;  
1.8 establishing uniform requirements for public assistance programs related  
1.9 to income calculation, reporting income, and correcting overpayments and  
1.10 underpayments; creating the Department of MNsure; modifying requirements  
1.11 for reporting maltreatment of minors; establishing the Minnesota ABLE plan  
1.12 and accounts; modifying child support provisions; establishing standards for  
1.13 withdrawal management programs; modifying requirements for background  
1.14 studies; making changes to provisions governing the health information  
1.15 exchange; authorizing rulemaking; requiring reports; making technical changes;  
1.16 modifying certain fees for Department of Health programs; modifying fees  
1.17 of certain health-related licensing boards; making human services forecast  
1.18 adjustments; appropriating money; amending Minnesota Statutes 2014, sections  
1.19 13.3806, subdivision 4; 13.46, subdivisions 2, 7; 13.461, by adding a subdivision;  
1.20 15.01; 15A.0815, subdivision 2; 16A.724, subdivision 2; 43A.241; 62A.02,  
1.21 subdivision 2; 62A.045; 62J.497, subdivisions 1, 3, 4, 5; 62J.498; 62J.4981;  
1.22 62J.4982, subdivisions 4, 5; 62J.692, subdivision 4; 62M.01, subdivision  
1.23 2; 62M.02, subdivisions 12, 14, 15, 17, by adding subdivisions; 62M.05,  
1.24 subdivisions 3a, 3b, 4; 62M.06, subdivisions 2, 3; 62M.07; 62M.09, subdivision  
1.25 3; 62M.10, subdivision 7; 62M.11; 62Q.02; 62U.02, subdivisions 1, 2, 3, 4;  
1.26 62U.04, subdivision 11; 62V.02, subdivisions 2, 11, by adding a subdivision;  
1.27 62V.03; 62V.05; 62V.06; 62V.07; 62V.08; 119B.011, subdivision 15; 119B.025,  
1.28 subdivision 1; 119B.035, subdivision 4; 119B.07; 119B.09, subdivision 4;  
1.29 119B.10, subdivision 1; 119B.11, subdivision 2a; 119B.125, by adding a  
1.30 subdivision; 144.057, subdivision 1; 144.1501, subdivisions 1, 2, 3, 4; 144.215,  
1.31 by adding a subdivision; 144.225, subdivision 4; 144.291, subdivision 2; 144.293,  
1.32 subdivisions 6, 8; 144.298, subdivisions 2, 3; 144.3831, subdivision 1; 144.9501,  
1.33 subdivisions 6d, 22b, 26b, by adding subdivisions; 144.9505; 144.9508;  
1.34 144A.70, subdivision 6, by adding a subdivision; 144A.71; 144A.72; 144A.73;  
1.35 144D.01, by adding a subdivision; 144E.001, by adding a subdivision; 144E.275,  
1.36 subdivision 1, by adding a subdivision; 144E.50; 144F.01, subdivision 5;  
1.37 145.928, by adding a subdivision; 145A.131, subdivision 1; 148.57, subdivisions  
1.38 1, 2; 148.59; 148E.075; 148E.080, subdivisions 1, 2; 148E.180, subdivisions 2,  
1.39

2.1 5; 149A.20, subdivisions 5, 6; 149A.40, subdivision 11; 149A.65; 149A.92,  
 2.2 subdivision 1; 149A.97, subdivision 7; 150A.091, subdivisions 4, 5, 11, by adding  
 2.3 subdivisions; 150A.31; 151.065, subdivisions 1, 2, 3, 4; 151.58, subdivisions 2,  
 2.4 5; 157.16; 169.686, subdivision 3; 174.29, subdivision 1; 174.30, subdivisions 3,  
 2.5 4, by adding subdivisions; 245.4661, subdivisions 5, 6, by adding subdivisions;  
 2.6 245.467, subdivision 6; 245.469, by adding a subdivision; 245.4876, subdivision  
 2.7 7; 245.4889, subdivision 1, by adding a subdivision; 245C.03, by adding a  
 2.8 subdivision; 245C.08, subdivision 1; 245C.10, by adding subdivisions; 245C.12;  
 2.9 246.18, subdivision 8; 246.54, subdivision 1; 246B.01, subdivision 2b; 246B.10;  
 2.10 253B.18, subdivisions 4c, 5; 254B.05, subdivision 5; 254B.12, subdivision 2;  
 2.11 256.01, by adding subdivisions; 256.015, subdivision 7; 256.017, subdivision  
 2.12 1; 256.478; 256.741, subdivisions 1, 2; 256.962, subdivision 5, by adding a  
 2.13 subdivision; 256.969, subdivisions 1, 2b, 3a, 3c, 9; 256.975, subdivision 8;  
 2.14 256B.056, subdivision 5c; 256B.057, subdivision 9; 256B.059, subdivision  
 2.15 5; 256B.06, by adding a subdivision; 256B.0615, subdivision 3; 256B.0622,  
 2.16 subdivisions 1, 2, 3, 4, 5, 7, 8, 9, 10, by adding a subdivision; 256B.0624,  
 2.17 subdivision 7; 256B.0625, subdivisions 3b, 9, 13, 13e, 13h, 14, 17, 17a, 18a,  
 2.18 18e, 31, 48, 57, 58, by adding subdivisions; 256B.0631; 256B.072; 256B.0757;  
 2.19 256B.0916, subdivisions 2, 11, by adding a subdivision; 256B.441, by adding  
 2.20 a subdivision; 256B.49, subdivision 26, by adding a subdivision; 256B.4913,  
 2.21 subdivisions 4a, 5; 256B.4914, subdivisions 2, 8, 10, 14, 15; 256B.69,  
 2.22 subdivisions 5a, 5i, 6, 9c, 9d, by adding a subdivision; 256B.75; 256B.76,  
 2.23 subdivisions 2, 4, 7; 256B.767; 256D.01, subdivision 1a; 256D.02, subdivision  
 2.24 8, by adding subdivisions; 256D.06, subdivision 1; 256D.405, subdivision 3;  
 2.25 256E.35, subdivision 2, by adding a subdivision; 256I.03, subdivisions 3,  
 2.26 7, by adding subdivisions; 256I.04; 256I.05, subdivisions 1c, 1g; 256I.06,  
 2.27 subdivisions 2, 6, 7, 8; 256J.08, subdivisions 26, 86; 256J.24, subdivisions  
 2.28 5, 5a; 256J.30, subdivisions 1, 9; 256J.35; 256J.40; 256J.95, subdivision 19;  
 2.29 256K.45, subdivisions 1a, 6; 256L.01, subdivisions 3a, 5; 256L.03, subdivision  
 2.30 5; 256L.04, subdivisions 1a, 1c, 7b; 256L.05, subdivisions 3, 3a, 4, by adding  
 2.31 a subdivision; 256L.06, subdivision 3; 256L.11, by adding a subdivision;  
 2.32 256L.121, subdivision 1; 256L.15, subdivision 2; 256N.22, subdivisions 9,  
 2.33 10; 256N.24, subdivision 4; 256N.25, subdivision 1; 256N.27, subdivision 2;  
 2.34 256P.001; 256P.01, subdivision 3, by adding subdivisions; 256P.02, by adding  
 2.35 a subdivision; 256P.03, subdivision 1; 256P.04, subdivisions 1, 4; 256P.05,  
 2.36 subdivision 1; 257.0755, subdivisions 1, 2; 257.0761, subdivision 1; 257.0766,  
 2.37 subdivision 1; 257.0769, subdivision 1; 257.75, subdivisions 3, 5; 259A.75;  
 2.38 260C.007, subdivisions 27, 32; 260C.203; 260C.212, subdivision 1, by adding  
 2.39 subdivisions; 260C.221; 260C.331, subdivision 1; 260C.451, subdivisions 2, 6;  
 2.40 260C.515, subdivision 5; 260C.521, subdivisions 1, 2; 260C.607, subdivision  
 2.41 4; 282.241, subdivision 1; 290.0671, subdivision 6; 297A.70, subdivision 7;  
 2.42 514.73; 514.981, subdivision 2; 518A.26, subdivision 14; 518A.32, subdivision  
 2.43 2; 518A.39, subdivision 1, by adding a subdivision; 518A.41, subdivisions 1, 3,  
 2.44 4, 14, 15; 518A.43, by adding a subdivision; 518A.46, subdivision 3, by adding  
 2.45 a subdivision; 518A.51; 518A.53, subdivisions 1, 4, 10; 518A.60; 518C.802;  
 2.46 580.032, subdivision 1; 626.556, subdivisions 1, as amended, 2, 3, 6a, 7, as  
 2.47 amended, 10, 10e, 10j, 10m, 11c, by adding subdivisions; Laws 2008, chapter  
 2.48 363, article 18, section 3, subdivision 5; Laws 2013, chapter 108, article 14,  
 2.49 section 12, as amended; Laws 2014, chapter 189, sections 5; 10; 11; 16; 17; 18;  
 2.50 19; 23; 24; 27; 28; 29; 31; 43; 50; 51; 73; Laws 2014, chapter 312, article 24,  
 2.51 section 45, subdivision 2; proposing coding for new law in Minnesota Statutes,  
 2.52 chapters 15; 62A; 62M; 62Q; 62V; 144; 144D; 245; 246B; 256B; 256E; 256M;  
 2.53 256P; 518A; proposing coding for new law as Minnesota Statutes, chapters 245F;  
 2.54 256Q; repealing Minnesota Statutes 2014, sections 62V.04; 62V.09; 62V.11;  
 2.55 144E.52; 148E.060, subdivision 12; 256.969, subdivisions 23, 30; 256B.69,  
 2.56 subdivision 32; 256D.0513; 256D.06, subdivision 8; 256D.09, subdivision 6;  
 2.57 256D.49; 256J.38; 256L.02, subdivision 3; 256L.05, subdivisions 1b, 1c, 3c, 5;

3.1 256L.11, subdivision 7; 257.0768; 290.0671, subdivision 6a; Minnesota Rules,  
3.2 parts 3400.0170, subparts 5, 6, 12, 13; 8840.5900, subparts 12, 14.

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

3.4 **ARTICLE 1**

3.5 **CHILDREN AND FAMILY SERVICES**

3.6 Section 1. Minnesota Statutes 2014, section 119B.07, is amended to read:

3.7 **119B.07 USE OF MONEY.**

3.8 Subdivision 1. Uses of money. (a) Money for persons listed in sections 119B.03,  
3.9 subdivision 3, and 119B.05, subdivision 1, shall be used to reduce the costs of child care  
3.10 for students, including the costs of child care for students while employed if enrolled in an  
3.11 eligible education program at the same time and making satisfactory progress towards  
3.12 completion of the program. Counties may not limit the duration of child care subsidies for  
3.13 a person in an employment or educational program, except when the person is found to be  
3.14 ineligible under the child care fund eligibility standards. Any limitation must be based  
3.15 on a person's employment plan in the case of an MFIP participant, and county policies  
3.16 included in the child care fund plan. The maximum length of time a student is eligible for  
3.17 child care assistance under the child care fund for education and training is no more than  
3.18 the time necessary to complete the credit requirements for an associate or baccalaureate  
3.19 degree as determined by the educational institution, excluding basic or remedial education  
3.20 programs needed to prepare for postsecondary education or employment.

3.21 Subd. 2. Eligibility. (b) To be eligible, the student must be in good standing  
3.22 and be making satisfactory progress toward the degree. Time limitations for child care  
3.23 assistance do not apply to basic or remedial educational programs needed to prepare  
3.24 for postsecondary education or employment. These programs include: high school,  
3.25 general equivalency diploma, and English as a second language. Programs exempt from  
3.26 this time limit must not run concurrently with a postsecondary program. If an MFIP  
3.27 participant who is receiving MFIP child care assistance under this chapter moves to  
3.28 another county, continues to participate in educational or training programs authorized in  
3.29 their employment plans, and continues to be eligible for MFIP child care assistance under  
3.30 this chapter, the MFIP participant must receive continued child care assistance from the  
3.31 county responsible for their current employment plan, under section 256G.07.

3.32 Subd. 3. Amount of child care assistance authorized. (a) If the student meets the  
3.33 conditions of subdivisions 1 and 2, child care assistance must be authorized for all hours  
3.34 of actual class time and credit hours, including independent study and internships; up to  
3.35 two hours of travel time per day; and, for postsecondary students, two hours per week

4.1 per credit hour for study time and academic appointments. For an MFIP or DWP student  
 4.2 whose employment plan specifies a different time frame, child care assistance must be  
 4.3 authorized according to the time frame specified in the employment plan.

4.4 (b) The amount of child care assistance authorized must take into consideration the  
 4.5 amount of time the parent reports on the application or redetermination form that the child  
 4.6 attends preschool, a Head Start program, or school while the parent is participating in  
 4.7 the parent's authorized activity.

4.8 (c) When the conditions in paragraph (d) do not apply, the applicant's or participant's  
 4.9 activity schedule does not need to be verified. The amount of child care assistance  
 4.10 authorized may be used during the applicant's or participant's activity or at other times, as  
 4.11 determined by the family, to meet the developmental needs of the child.

4.12 (d) Care must be authorized based on the applicant's or participant's verified activity  
 4.13 schedule when:

4.14 (1) the family requests to regularly receive care from more than one provider per child;

4.15 (2) the family requests a legal nonlicensed provider;

4.16 (3) the family includes more than one applicant or participant; or

4.17 (4) an applicant or participant is employed by a provider that is licensed by the

4.18 Department of Human Services or enrolled as a medical assistance provider in the

4.19 Minnesota health care program's provider directory.

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

4.21 Sec. 2. Minnesota Statutes 2014, section 119B.10, subdivision 1, is amended to read:

4.22 Subdivision 1. **Assistance for persons seeking and retaining employment.** (a)

4.23 Persons who are seeking employment and who are eligible for assistance under this  
 4.24 section are eligible to receive up to 240 hours of child care assistance per calendar year.

4.25 (b) Employed persons who work at least an average of 20 hours and full-time  
 4.26 students who work at least an average of ten hours a week and receive at least a minimum  
 4.27 wage for all hours worked are eligible for continued child care assistance for employment.  
 4.28 For purposes of this section, work-study programs must be counted as employment. Child  
 4.29 care assistance ~~during employment~~ for employed participants must be authorized as  
 4.30 provided in paragraphs (c) ~~and~~ (d), (e), (f), and (g).

4.31 (c) When the person works for an hourly wage and the hourly wage is equal to or  
 4.32 greater than the applicable minimum wage, child care assistance shall be provided for the  
 4.33 actual hours of employment, break, and mealtime during the employment and travel time  
 4.34 up to two hours per day.

5.1 (d) When the person does not work for an hourly wage, child care assistance must be  
5.2 provided for the lesser of:

5.3 (1) the amount of child care determined by dividing gross earned income by the  
5.4 applicable minimum wage, up to one hour every eight hours for meals and break time,  
5.5 plus up to two hours per day for travel time; or

5.6 (2) the amount of child care equal to the actual amount of child care used during  
5.7 employment, including break and mealtime during employment, and travel time up to  
5.8 two hours per day.

5.9 (e) The amount of child care assistance authorized must take into consideration the  
5.10 amount of time the parent reports on the application or redetermination form that the child  
5.11 attends preschool, a Head Start program, or school while the parent is participating in  
5.12 the parent's authorized activity.

5.13 (f) When the conditions in paragraph (g) do not apply, the applicant's or participant's  
5.14 activity schedule does not need to be verified. The amount of child care assistance  
5.15 authorized may be used during the applicant's or participant's activity or at other times, as  
5.16 determined by the family, to meet the developmental needs of the child.

5.17 (g) Care must be authorized based on the applicant's or participant's verified activity  
5.18 schedule when:

5.19 (1) the family requests to regularly receive care from more than one provider per child;

5.20 (2) the family requests a legal nonlicensed provider;

5.21 (3) the family includes more than one applicant or participant; or

5.22 (4) an applicant or participant is employed by a provider that is licensed by the  
5.23 Department of Human Services or enrolled as a medical assistance provider in the  
5.24 Minnesota health care program's provider directory.

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

5.26 Sec. 3. Minnesota Statutes 2014, section 119B.11, subdivision 2a, is amended to read:

5.27 Subd. 2a. **Recovery of overpayments.** (a) An amount of child care assistance  
5.28 paid to a recipient in excess of the payment due is recoverable by the county agency  
5.29 under paragraphs (b) and (c), even when the overpayment was caused by ~~agency error or~~  
5.30 ~~circumstances outside the responsibility and control of the family or provider.~~

5.31 (b) An overpayment must be recouped or recovered from the family if the  
5.32 overpayment benefited the family by causing the family to pay less for child care expenses  
5.33 than the family otherwise would have been required to pay under child care assistance  
5.34 program requirements. Family overpayments must be established and recovered in  
5.35 accordance with clauses (1) to (5).

6.1 (1) If the overpayment is estimated to be less than \$500, the overpayment must not be  
6.2 established or collected. Any portion of the overpayment that occurred more than one year  
6.3 prior to the date of the overpayment determination must not be established or collected.

6.4 (2) If the family remains eligible for child care assistance and an overpayment is  
6.5 established, the overpayment must be recovered through recoupment as identified in  
6.6 Minnesota Rules, part 3400.0187, except that the overpayments must be calculated and  
6.7 collected on a service period basis. If the family no longer remains eligible for child  
6.8 care assistance, the county may choose to initiate efforts to recover overpayments from  
6.9 the family for overpayment less than \$50.

6.10 (3) If the family is no longer eligible for child care assistance and an overpayment  
6.11 is greater than or equal to \$50 established, the county shall seek voluntary repayment of  
6.12 the overpayment from the family.

6.13 (4) If the county is unable to recoup the overpayment through voluntary repayment,  
6.14 the county shall initiate civil court proceedings to recover the overpayment unless the  
6.15 county's costs to recover the overpayment will exceed the amount of the overpayment.

6.16 (5) A family with an outstanding debt under this subdivision is not eligible for  
6.17 child care assistance until:

6.18 ~~(1)~~ (i) the debt is paid in full; or

6.19 ~~(2)~~ (ii) satisfactory arrangements are made with the county to retire the debt  
6.20 consistent with the requirements of this chapter and Minnesota Rules, chapter 3400, and  
6.21 the family is in compliance with the arrangements.

6.22 (c) The county must recover an overpayment from a provider if the overpayment did  
6.23 not benefit the family by causing it to receive more child care assistance or to pay less  
6.24 for child care expenses than the family otherwise would have been eligible to receive  
6.25 or required to pay under child care assistance program requirements, and benefited the  
6.26 provider by causing the provider to receive more child care assistance than otherwise  
6.27 would have been paid on the family's behalf under child care assistance program  
6.28 requirements. If the provider continues to care for children receiving child care assistance,  
6.29 the overpayment must be recovered through reductions in child care assistance payments  
6.30 for services as described in an agreement with the county. The provider may not charge  
6.31 families using that provider more to cover the cost of recouping the overpayment. If the  
6.32 provider no longer cares for children receiving child care assistance, the county may  
6.33 choose to initiate efforts to recover overpayments of less than \$50 from the provider. If the  
6.34 overpayment is greater than or equal to \$50, the county shall seek voluntary repayment of  
6.35 the overpayment from the provider. If the county is unable to recoup the overpayment  
6.36 through voluntary repayment, the county shall initiate civil court proceedings to recover

7.1 the overpayment unless the county's costs to recover the overpayment will exceed the  
7.2 amount of the overpayment. A provider with an outstanding debt under this subdivision is  
7.3 not eligible to care for children receiving child care assistance until:

7.4 (1) the debt is paid in full; or

7.5 (2) satisfactory arrangements are made with the county to retire the debt consistent  
7.6 with the requirements of this chapter and Minnesota Rules, chapter 3400, and the provider  
7.7 is in compliance with the arrangements.

7.8 (d) When both the family and the provider acted together to intentionally cause the  
7.9 overpayment, both the family and the provider are jointly liable for the overpayment  
7.10 regardless of who benefited from the overpayment. The county must recover the  
7.11 overpayment as provided in paragraphs (b) and (c). When the family or the provider is in  
7.12 compliance with a repayment agreement, the party in compliance is eligible to receive  
7.13 child care assistance or to care for children receiving child care assistance despite the  
7.14 other party's noncompliance with repayment arrangements.

7.15 (e) A family overpayment designated solely as an agency error must not be  
7.16 established or collected. This paragraph does not apply: (1) to recipient families if the  
7.17 overpayment was caused in any part by wrongfully obtaining assistance under section  
7.18 256.98; or (2) to benefits paid pending appeal under section 119B.16, to the extent that  
7.19 the commissioner finds on appeal that the appellant was not eligible for the amount of  
7.20 child care assistance paid.

7.21 (f) A provider overpayment designated as an agency error that results from an  
7.22 incorrect maximum rate being applied must not be established or collected. All other  
7.23 provider overpayments designated as agency error must be established and collected.

7.24 (g) Notwithstanding any provision to the contrary in this subdivision, an  
7.25 overpayment must be collected, regardless of amount or time period, if the overpayment  
7.26 was caused by wrongfully obtaining assistance under section 256.98, or benefits paid while  
7.27 an action is pending appeal under section 119B.16, to the extent the commissioner finds  
7.28 on appeal that the appellant was not eligible for the amount of child care assistance paid.

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

7.30 Sec. 4. Minnesota Statutes 2014, section 119B.125, is amended by adding a subdivision  
7.31 to read:

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

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

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

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

8.10 (e) When a provider has been disqualified or convicted of fraud under section  
8.11 256.98, theft under section 609.52, or a federal crime relating to theft of state funds  
8.12 or fraudulent billing for a program administered by the commissioner or a county,  
8.13 recoupment or recovery must be sought regardless of the amount of overpayment.

8.14 Sec. 5. Minnesota Statutes 2014, section 245C.03, is amended by adding a subdivision  
8.15 to read:

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

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

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

8.22 Subd. 11. **Providers of group residential housing or supplementary services.**  
8.23 The commissioner shall recover the cost of background studies initiated by providers of  
8.24 group residential housing or supplementary services under section 256I.04 through a fee  
8.25 of no more than \$20 per study. The fees collected under this subdivision are appropriated  
8.26 to the commissioner for the purpose of conducting background studies.

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

8.28 Sec. 7. Minnesota Statutes 2014, section 256.01, is amended by adding a subdivision  
8.29 to read:

8.30 Subd. 12a. **Department of Human Services child fatality and near fatality**  
8.31 **review team.** The commissioner shall establish a Department of Human Services child  
8.32 fatality and near fatality review team to review child fatalities and near fatalities due to



9.1 child maltreatment and child fatalities and near fatalities that occur in licensed facilities  
9.2 and are not due to natural causes. The review team shall assess the entire child protection  
9.3 services process from the point of a mandated reporter reporting the alleged maltreatment  
9.4 through the ongoing case management process. Department staff shall lead and conduct  
9.5 on-site local reviews and utilize supervisors from local county and tribal child welfare  
9.6 agencies as peer reviewers. The review process must focus on critical elements of the case  
9.7 and on the involvement of the child and family with the county or tribal child welfare  
9.8 agency. The review team shall identify necessary program improvement planning to  
9.9 address any practice issues identified and training and technical assistance needs of  
9.10 the local agency. Summary reports of each review shall be provided to the state child  
9.11 mortality review panel when completed.

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

9.14 Subd. 14c. **Early intervention support and services for at-risk American Indian**  
9.15 **families.** (a) The commissioner shall authorize grants to tribal child welfare agencies and  
9.16 urban Indian organizations for the purpose of providing early intervention support and  
9.17 services to prevent child maltreatment for at-risk American Indian families.

9.18 (b) The commissioner is authorized to develop program eligibility criteria, early  
9.19 intervention service delivery procedures, and reporting requirements for agencies and  
9.20 organizations receiving grants.

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

9.22 Subdivision 1. **Authority and purpose.** The commissioner shall administer a  
9.23 compliance system for the Minnesota family investment program, the food stamp or food  
9.24 support program, emergency assistance, general assistance, medical assistance, emergency  
9.25 general assistance, Minnesota supplemental assistance, group residential housing,  
9.26 preadmission screening, alternative care grants, the child care assistance program, and  
9.27 all other programs administered by the commissioner or on behalf of the commissioner  
9.28 under the powers and authorities named in section 256.01, subdivision 2. The purpose of  
9.29 the compliance system is to permit the commissioner to supervise the administration of  
9.30 public assistance programs and to enforce timely and accurate distribution of benefits,  
9.31 completeness of service and efficient and effective program management and operations,  
9.32 to increase uniformity and consistency in the administration and delivery of public  
9.33 assistance programs throughout the state, and to reduce the possibility of sanctions and  
9.34 fiscal disallowances for noncompliance with federal regulations and state statutes. The

10.1 commissioner, or the commissioner's representative, may issue administrative subpoenas  
 10.2 as needed in administering the compliance system.

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

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

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

10.10 (b) The term "public assistance" as used in this chapter and chapters 257, 518, 518A,  
 10.11 and 518C, includes any form of assistance provided under the AFDC program formerly  
 10.12 codified in sections 256.72 to 256.87, MFIP and MFIP-R formerly codified under chapter  
 10.13 256, MFIP under chapter 256J, work first program formerly codified under chapter 256K;  
 10.14 child care assistance provided through the child care fund under chapter 119B; any form  
 10.15 of medical assistance under chapter 256B; ~~MinnesotaCare under chapter 256L~~; and foster  
 10.16 care as provided under title IV-E of the Social Security Act. MinnesotaCare and health  
 10.17 plans subsidized by federal premium tax credits or federal cost-sharing reductions are not  
 10.18 considered public assistance for purposes of a child support referral.

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

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

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

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

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

10.28 Subd. 2. **Assignment of support and maintenance rights.** (a) An individual  
 10.29 receiving public assistance in the form of assistance under any of the following programs:  
 10.30 the AFDC program formerly codified in sections 256.72 to 256.87, MFIP under chapter  
 10.31 256J, MFIP-R and MFIP formerly codified under chapter 256, or work first program  
 10.32 formerly codified under chapter 256K is considered to have assigned to the state at the  
 10.33 time of application all rights to child support and maintenance from any other person the  
 10.34 applicant or recipient may have in the individual's own behalf or in the behalf of any other

11.1 family member for whom application for public assistance is made. An assistance unit is  
11.2 ineligible for the Minnesota family investment program unless the caregiver assigns all  
11.3 rights to child support and maintenance benefits according to this section.

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

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

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

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

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

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

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

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

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

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

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

12.1 Sec. 12. [256E.345] HEALTHY EATING, HERE AT HOME.

12.2 Subdivision 1. **Establishment.** The healthy eating, here at home program is  
12.3 established to provide incentives for low-income Minnesotans to use Supplemental  
12.4 Nutrition Assistance Program (SNAP) benefits for healthy purchases at Minnesota-based  
12.5 farmers' markets.

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

12.7 (b) "Healthy eating, here at home" means a program administered by the  
12.8 commissioner to provide incentives for low-income Minnesotans to use SNAP benefits for  
12.9 healthy purchases at Minnesota-based farmers' markets.

12.10 (c) "Healthy purchases" means SNAP-eligible foods.

12.11 (d) "Minnesota-based farmers' market" means a physical market as defined in section  
12.12 28A.151, subdivision 1, paragraph (b), and also includes mobile markets.

12.13 (e) "Voucher" means a physical or electronic credit.

12.14 (f) "Eligible household" means an individual or family that is determined to be a  
12.15 recipient of SNAP.

12.16 Subd. 3. **Grants.** The commissioner shall award grant funds to nonprofit  
12.17 organizations that work with Minnesota-based farmers' markets to provide up to \$10  
12.18 vouchers to SNAP participants who use electronic benefits transfer (EBT) cards for  
12.19 healthy purchases. Funds may also be provided for vouchers distributed through nonprofit  
12.20 organizations engaged in healthy cooking and food education outreach to eligible  
12.21 households for use at farmers' markets. Funds appropriated under this section may not  
12.22 be used for healthy cooking classes or food education outreach. When awarding grants,  
12.23 the commissioner must consider how the nonprofit organizations will achieve geographic  
12.24 balance, including specific efforts to reach eligible households across the state, and the  
12.25 organizations' capacity to manage the programming and outreach.

12.26 Subd. 4. **Household eligibility; participation.** To be eligible for a healthy eating,  
12.27 here at home voucher, an eligible household must meet the SNAP eligibility requirements  
12.28 in state or federal law.

12.29 Subd. 5. **Permissible uses; information provided.** An eligible household may use  
12.30 the voucher toward healthy purchases at Minnesota-based farmers' markets. Every eligible  
12.31 household that receives a voucher must be informed of the allowable uses of the voucher.

12.32 Subd. 6. **Program reporting.** The nonprofit organizations that receive grant funds  
12.33 must report annually to the commissioner with information regarding the operation of the  
12.34 program, including the number of vouchers issued and the number of people served. To  
12.35 the extent practicable, the nonprofit organizations must report on the usage of the vouchers  
12.36 and evaluate the program's effectiveness.

13.1 Subd. 7. **Grocery inclusion.** The commissioner must submit a waiver request to  
13.2 the federal United States Department of Agriculture seeking approval for the inclusion of  
13.3 Minnesota grocery stores in this program so that SNAP participants may use the vouchers  
13.4 for healthy produce at grocery stores. Grocery store participation is voluntary and a  
13.5 grocery store's associated administrative costs will not be reimbursed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15.18 Subd. 9. **Direct contact.** "Direct contact" means providing face-to-face care,  
15.19 support, training, supervision, counseling, consultation, or medication assistance to  
15.20 recipients of group residential housing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16.28 Subd. 14. **Qualified professional.** "Qualified professional" means an individual as  
16.29 defined in section 256J.08, subdivision 73a, or Minnesota Rules, part 9530.6450, subpart  
16.30 3, 4, or 5; or an individual approved by the director of human services or a designee  
16.31 of the director.

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



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

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

17.5 **256I.04 ELIGIBILITY FOR GROUP RESIDENTIAL HOUSING PAYMENT.**

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

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

17.19 (b) The individual meets a category of eligibility under section 256D.05, subdivision  
 17.20 1, paragraph (a), clauses (1), (3), (5) to (9), and (14), and paragraph (b), if applicable, and  
 17.21 the individual's resources are less than the standards specified by section 256P.02, and  
 17.22 the individual's countable income as determined under sections 256D.01 to 256D.21, less  
 17.23 the medical assistance personal needs allowance under section 256B.35 is less than the  
 17.24 monthly rate specified in the agency's agreement with the provider of group residential  
 17.25 housing in which the individual resides.

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

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

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

17.34 ~~The plan must be signed or countersigned by any of the following employees of the~~  
 17.35 ~~county of financial responsibility: the director of human services or a designee of the~~

18.1 ~~director; a social worker; or a case aide~~ professional statement of need under section  
18.2 256I.03, subdivision 12.

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

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

18.8 Subd. 1b. **Optional state supplements to SSI.** Group residential housing payments  
18.9 made on behalf of persons eligible under subdivision 1, paragraph (a), are optional state  
18.10 supplements to the SSI program.

18.11 Subd. 1c. **Interim assistance.** Group residential housing payments made on behalf  
18.12 of persons eligible under subdivision 1, paragraph (b), are considered interim assistance  
18.13 payments to applicants for the federal SSI program.

18.14 Subd. 2. **Date of eligibility.** An individual who has met the eligibility requirements  
18.15 of subdivision 1, shall have a group residential housing payment made on the individual's  
18.16 behalf from the first day of the month in which a signed application form is received by  
18.17 a county agency, or the first day of the month in which all eligibility factors have been  
18.18 met, whichever is later.

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

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

18.29 (2) the residence is: (i) licensed by the commissioner of human services under  
18.30 Minnesota Rules, parts 9555.5050 to 9555.6265; (ii) certified by a county human services  
18.31 agency prior to July 1, 1992, using the standards under Minnesota Rules, parts 9555.5050  
18.32 to 9555.6265; (iii) ~~a residence~~ licensed by the commissioner under Minnesota Rules, parts  
18.33 2960.0010 to 2960.0120, with a variance under section 245A.04, subdivision 9; or (iv)  
18.34 licensed under section 245D.02, subdivision 4a, as a community residential setting by  
18.35 the commissioner of human services; or

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

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

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

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

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

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

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

19.20 (1) have skills and knowledge acquired through:

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

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

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

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

19.27 (2) hold a current Minnesota driver's license appropriate to the vehicle driven if  
 19.28 transporting participants;

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

19.31 (4) complete group residential housing orientation training offered by the  
 19.32 commissioner.

19.33 Subd. 2b. **Group residential housing agreements.** (a) Agreements between county  
 19.34 agencies and providers of group residential housing or supplementary services must be in  
 19.35 writing on a form developed and approved by the commissioner and must specify the name  
 19.36 and address under which the establishment subject to the agreement does business and

20.1 under which the establishment, or service provider, if different from the group residential  
 20.2 housing establishment, is licensed by the Department of Health or the Department of  
 20.3 Human Services; the specific license or registration from the Department of Health or the  
 20.4 Department of Human Services held by the provider and the number of beds subject to  
 20.5 that license; the address of the location or locations at which group residential housing is  
 20.6 provided under this agreement; the per diem and monthly rates that are to be paid from  
 20.7 group residential housing or supplementary service funds for each eligible resident at each  
 20.8 location; the number of beds at each location which are subject to the ~~group residential~~  
 20.9 ~~housing~~ agreement; whether the license holder is a not-for-profit corporation under section  
 20.10 501(c)(3) of the Internal Revenue Code; and a statement that the agreement is subject to  
 20.11 the provisions of sections 256I.01 to 256I.06 and subject to any changes to those sections.

20.12 (b) Providers are required to verify the following minimum requirements in the  
 20.13 agreement:

20.14 (1) current license or registration, including authorization if managing or monitoring  
 20.15 medications;

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

20.17 (3) the provision of group residential housing;

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

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

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

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

20.24 Subd. 2c. ~~Crisis shelters~~ **Background study requirements.** ~~Secure crisis shelters~~  
 20.25 ~~for battered women and their children designated by the Minnesota Department of~~  
 20.26 ~~Corrections are not group residences under this chapter~~ (a) Effective July 1, 2016, a  
 20.27 provider of group residential housing or supplementary services must initiate background  
 20.28 studies in accordance with chapter 245C of the following individuals:

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

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

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

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

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

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

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

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

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

21.19 (c) Notwithstanding paragraph (b), if the commissioner learns of a curable material  
21.20 breach of the agreement by the provider, the commissioner shall provide the provider  
21.21 with a written notice of the breach and allow ten days to cure the breach. If the provider  
21.22 does not cure the breach within the time allowed, the provider shall be in default of the  
21.23 agreement and the commissioner may terminate the agreement immediately thereafter. If  
21.24 the provider has breached a material term of the agreement and cure is not possible, the  
21.25 commissioner may immediately terminate the agreement.

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

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

21.35 Subd. 2f. **Required services.** In licensed and registered settings under subdivision  
21.36 2a, providers shall ensure that participants have at a minimum:

- 22.1 (1) food preparation and service for three nutritional meals a day on site;  
 22.2 (2) a bed, clothing storage, linen, bedding, laundering, and laundry supplies or  
 22.3 service;  
 22.4 (3) housekeeping, including cleaning and lavatory supplies or service; and  
 22.5 (4) maintenance and operation of the building and grounds, including heat, water,  
 22.6 garbage removal, electricity, telephone for the site, cooling, supplies, and parts and tools  
 22.7 to repair and maintain equipment and facilities.

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

22.11 **Subd. 3. Moratorium on development of group residential housing beds.** (a)  
 22.12 **County** Agencies shall not enter into agreements for new group residential housing beds  
 22.13 with total rates in excess of the MSA equivalent rate except:

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

22.17 (2) up to 80 beds in a single, specialized facility located in Hennepin County that will  
 22.18 provide housing for chronic inebriates who are repetitive users of detoxification centers  
 22.19 and are refused placement in emergency shelters because of their state of intoxication,  
 22.20 and planning for the specialized facility must have been initiated before July 1, 1991,  
 22.21 in anticipation of receiving a grant from the Housing Finance Agency under section  
 22.22 462A.05, subdivision 20a, paragraph (b);

22.23 (3) notwithstanding the provisions of subdivision 2a, for up to 190 supportive  
 22.24 housing units in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a  
 22.25 mental illness, a history of substance abuse, or human immunodeficiency virus or acquired  
 22.26 immunodeficiency syndrome. For purposes of this section, "homeless adult" means a  
 22.27 person who is living on the street or in a shelter or discharged from a regional treatment  
 22.28 center, community hospital, or residential treatment program and has no appropriate  
 22.29 housing available and lacks the resources and support necessary to access appropriate  
 22.30 housing. At least 70 percent of the supportive housing units must serve homeless adults  
 22.31 with mental illness, substance abuse problems, or human immunodeficiency virus or  
 22.32 acquired immunodeficiency syndrome who are about to be or, within the previous six  
 22.33 months, has been discharged from a regional treatment center, or a state-contracted  
 22.34 psychiatric bed in a community hospital, or a residential mental health or chemical  
 22.35 dependency treatment program. If a person meets the requirements of subdivision 1,  
 22.36 paragraph (a), and receives a federal or state housing subsidy, the group residential housing

23.1 rate for that person is limited to the supplementary rate under section 256I.05, subdivision  
 23.2 1a, and is determined by subtracting the amount of the person's countable income that  
 23.3 exceeds the MSA equivalent rate from the group residential housing supplementary rate.  
 23.4 A resident in a demonstration project site who no longer participates in the demonstration  
 23.5 program shall retain eligibility for a group residential housing payment in an amount  
 23.6 determined under section 256I.06, subdivision 8, using the MSA equivalent rate. Service  
 23.7 funding under section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching  
 23.8 funds are available and the services can be provided through a managed care entity. If  
 23.9 federal matching funds are not available, then service funding will continue under section  
 23.10 256I.05, subdivision 1a;

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

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

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

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

23.26 (8) for a group residential facility in Hennepin County with a capacity of up to 48  
 23.27 beds that has been licensed since 1978 as a board and lodging facility and that until August  
 23.28 1, 2007, operated as a licensed chemical dependency treatment program.

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

24.1 Subd. 4. **Rental assistance.** For participants in the Minnesota supportive housing  
 24.2 demonstration program under subdivision 3, paragraph (a), clause (5), notwithstanding  
 24.3 the provisions of section 256I.06, subdivision 8, the amount of the group residential  
 24.4 housing payment for room and board must be calculated by subtracting 30 percent of the  
 24.5 recipient's adjusted income as defined by the United States Department of Housing and  
 24.6 Urban Development for the Section 8 program from the fair market rent established for the  
 24.7 recipient's living unit by the federal Department of Housing and Urban Development. This  
 24.8 payment shall be regarded as a state housing subsidy for the purposes of subdivision 3.  
 24.9 Notwithstanding the provisions of section 256I.06, subdivision 6, the recipient's countable  
 24.10 income will only be adjusted when a change of greater than \$100 in a month occurs or  
 24.11 upon annual redetermination of eligibility, whichever is sooner. ~~The commissioner is~~  
 24.12 ~~directed to study the feasibility of developing a rental assistance program to serve persons~~  
 24.13 ~~traditionally served in group residential housing settings and report to the legislature by~~  
 24.14 ~~February 15, 1999.~~

24.15 **EFFECTIVE DATE.** Subdivision 1, paragraph (b), is effective September 1, 2015.

24.16 Sec. 25. Minnesota Statutes 2014, section 256I.05, subdivision 1c, is amended to read:

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

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

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

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

24.33 (d) When a group residential housing rate is used to pay for an individual's room  
 24.34 and board, or other costs necessary to provide room and board, the rate payable to  
 24.35 the residence must continue for up to 18 calendar days per incident that the person is



25.1 temporarily absent from the residence, not to exceed 60 days in a calendar year, if the  
 25.2 absence or absences have received the prior approval of the county agency's social service  
 25.3 staff. Prior approval is not required for emergency absences due to crisis, illness, or injury.

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

25.10 (f) Until June 30, 1994, ~~a county~~ an agency may increase by up to five percent the  
 25.11 total rate paid for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33  
 25.12 to 256D.54 who reside in residences that are licensed by the commissioner of health as  
 25.13 a boarding care home, but are not certified for the purposes of the medical assistance  
 25.14 program. However, an increase under this clause must not exceed an amount equivalent to  
 25.15 65 percent of the 1991 medical assistance reimbursement rate for nursing home resident  
 25.16 class A, in the geographic grouping in which the facility is located, as established under  
 25.17 Minnesota Rules, parts 9549.0050 to 9549.0058.

25.18 Sec. 26. Minnesota Statutes 2014, section 256I.05, subdivision 1g, is amended to read:

25.19 Subd. 1g. **Supplementary service rate for certain facilities.** ~~On or after July 1,~~  
 25.20 ~~2005, a county~~ An agency may negotiate a supplementary service rate for recipients of  
 25.21 assistance under section 256I.04, subdivision 1, paragraph (a) or (b), who ~~relocate from a~~  
 25.22 ~~homeless shelter licensed and registered prior to December 31, 1996, by the Minnesota~~  
 25.23 ~~Department of Health under section 157.17, to~~ have experienced long-term homelessness  
 25.24 and who live in a supportive housing establishment developed and funded in whole or in  
 25.25 part with funds provided specifically as part of the plan to end long-term homelessness  
 25.26 required under Laws 2003, chapter 128, article 15, section 9, not to exceed \$456.75 under  
 25.27 section 256I.04, subdivision 2a, paragraph (b), clause (2).

25.28 Sec. 27. Minnesota Statutes 2014, section 256I.06, subdivision 2, is amended to read:

25.29 Subd. 2. **Time of payment.** A county agency may make payments to a group  
 25.30 residence in advance for an individual whose stay in the group residence is expected  
 25.31 to last beyond the calendar month for which the payment is made ~~and who does not~~  
 25.32 ~~expect to receive countable earned income during the month for which the payment is~~  
 25.33 ~~made.~~ Group residential housing payments made by a county agency on behalf of an  
 25.34 individual who is not expected to remain in the group residence beyond the month for

26.1 which payment is made must be made subsequent to the individual's departure from the  
 26.2 group residence. ~~Group residential housing payments made by a county agency on behalf~~  
 26.3 ~~of an individual with countable earned income must be made subsequent to receipt of a~~  
 26.4 ~~monthly household report form.~~

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

26.6 Sec. 28. Minnesota Statutes 2014, section 256I.06, subdivision 6, is amended to read:

26.7 Subd. 6. **Reports.** Recipients must report changes in circumstances that affect  
 26.8 eligibility or group residential housing payment amounts, other than changes in earned  
 26.9 income, within ten days of the change. Recipients with countable earned income must  
 26.10 complete a ~~monthly~~ household report form at least once every six months. If the report  
 26.11 form is not received before the end of the month in which it is due, the county agency  
 26.12 must terminate eligibility for group residential housing payments. The termination shall  
 26.13 be effective on the first day of the month following the month in which the report was due.  
 26.14 If a complete report is received within the month eligibility was terminated, the individual  
 26.15 is considered to have continued an application for group residential housing payment  
 26.16 effective the first day of the month the eligibility was terminated.

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

26.18 Sec. 29. Minnesota Statutes 2014, section 256I.06, subdivision 7, is amended to read:

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

26.23 Sec. 30. Minnesota Statutes 2014, section 256I.06, subdivision 8, is amended to read:

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

26.31 (b) For an individual with earned income under paragraph (a), prospective budgeting  
 26.32 must be used to determine the amount of the individual's payment for the following

27.1 six-month period. An increase in income shall not affect an individual's eligibility or  
 27.2 payment amount until the month following the reporting month. A decrease in income shall  
 27.3 be effective the first day of the month after the month in which the decrease is reported.

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

27.5 Sec. 31. Minnesota Statutes 2014, section 256J.24, subdivision 5, is amended to read:

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

27.10 (b) The commissioner shall increase the cash assistance portion of the transitional  
 27.11 standard under paragraph (a) by \$100.

27.12 **EFFECTIVE DATE.** This section is effective October 1, 2015.

27.13 Sec. 32. Minnesota Statutes 2014, section 256J.24, subdivision 5a, is amended to read:

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

27.21 Sec. 33. Minnesota Statutes 2014, section 256K.45, subdivision 1a, is amended to read:

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

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

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

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

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

28.1 (3) transitional housing;

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

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

28.6 Homeless youth does not include persons incarcerated or otherwise detained under  
28.7 federal or state law.

28.8 (d) "Youth at risk of homelessness" means a person ~~21~~ 24 years of age or younger  
28.9 whose status or circumstances indicate a significant danger of experiencing homelessness  
28.10 in the near future. Status or circumstances that indicate a significant danger may include:  
28.11 (1) youth exiting out-of-home placements; (2) youth who previously were homeless; (3)  
28.12 youth whose parents or primary caregivers are or were previously homeless; (4) youth  
28.13 who are exposed to abuse and neglect in their homes; (5) youth who experience conflict  
28.14 with parents due to chemical or alcohol dependency, mental health disabilities, or other  
28.15 disabilities; and (6) runaways.

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

28.19 Sec. 34. Minnesota Statutes 2014, section 256K.45, subdivision 6, is amended to read:

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

28.26 Sec. 35. [256M.41] CHILD PROTECTION GRANT ALLOCATION TO  
28.27 ADDRESS STAFFING.

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

28.31 (1) 50 percent must be distributed on the basis of the child population residing in the  
28.32 county as determined by the most recent data of the state demographer;

29.1 (2) 25 percent must be distributed on the basis of the number of screened-in  
29.2 reports of child maltreatment under sections 626.556 and 626.5561, and in the county as  
29.3 determined by the most recent data of the commissioner; and

29.4 (3) 25 percent must be distributed on the basis of the number of open child  
29.5 protection case management cases in the county as determined by the most recent data of  
29.6 the commissioner.

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

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

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

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

29.18 (1) 80 percent of the allocation as determined in subdivision 1 must be paid to  
29.19 counties on or before July 10 of each year;

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

29.31 (3) ten percent of the allocation shall be withheld until the commissioner determines  
29.32 that the county has met the performance outcome threshold of 90 percent based on  
29.33 face-to-face visits by the case manager. In order to receive the performance allocation, the  
29.34 total number of visits made by caseworkers on a monthly basis to children in foster care  
29.35 and children receiving child protection services while residing in their home must be at  
29.36 least 90 percent of the total number of such visits that would occur if every child were

30.1 visited once per month. The commissioner shall make such determinations in January  
30.2 of each year and payments to counties meeting the performance outcome threshold  
30.3 shall occur in February of each year. Any withheld funds from this appropriation for  
30.4 counties that do not meet this requirement shall be reallocated by the commissioner to  
30.5 those counties meeting the requirement.

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

30.13 Sec. 36. [256M.42] CHILD PROTECTION GRANT ALLOCATION FOR  
30.14 COUNTY SERVICES.

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

30.18 (1) 50 percent must be distributed on the basis of the child population residing in the  
30.19 county as determined by the most recent data of the state demographer;

30.20 (2) 25 percent must be distributed on the basis of the number of screened-in  
30.21 reports of child maltreatment under sections 626.556 and 626.5561, and in the county as  
30.22 determined by the most recent data of the commissioner; and

30.23 (3) 25 percent must be distributed on the basis of the number of open child  
30.24 protection case management cases in the county as determined by the most recent data of  
30.25 the commissioner.

30.26 (b) Notwithstanding paragraph (a), no county shall be awarded an allocation of  
30.27 less than \$10,000.

30.28 Subd. 2. **Supplantation of existing funds.** Funds received by counties under this  
30.29 section must be used for additional child protection services and must not be used to  
30.30 supplant current county expenditures for these purposes.

30.31 Subd. 3. **Eligible services.** (a) Funds received under this section must be used  
30.32 for additional child protection services to support children and their families who have  
30.33 been identified to the child welfare system through the intake process. Examples of  
30.34 eligible services include, but are not limited to: family-based counseling; family-based  
30.35 life management; individual counseling; group counseling; family group decision-making;

31.1 parent support outreach; family-based crisis; family assessment response; concurrent  
 31.2 permanency planning; social and recreational; home-based support; homemaking; respite  
 31.3 care; legal; court-related; transportation; health-related; mental health screening; and  
 31.4 interpreter services.

31.5 (b) Funds may also be used for prioritized services in child care, Head Start, Early  
 31.6 Head Start, or home visiting for children in the child protection system to remove these  
 31.7 children from waiting lists in these programs.

31.8 (c) Services provided under this section shall be culturally affirming in access and  
 31.9 delivery for the recipient.

31.10 (d) The commissioner shall instruct counties on the eligible services and procedures  
 31.11 for claiming reimbursement.

31.12 Subd. 4. **American Indian child welfare projects.** Of the amount appropriated  
 31.13 under this section, \$75,000 shall be awarded to each tribe authorized under section 256.01,  
 31.14 subdivision 14b, to address child protection staffing and services.

31.15 Sec. 37. Minnesota Statutes 2014, section 256N.22, subdivision 9, is amended to read:

31.16 Subd. 9. **Death or incapacity of relative custodian or dissolution modification**  
 31.17 **of custody.** The Northstar kinship assistance agreement ends upon death or ~~dissolution~~  
 31.18 incapacity of the relative custodian or modification of the order for permanent legal and  
 31.19 physical custody of both relative custodians in the case of assignment of custody to two  
 31.20 individuals, or the sole relative custodian in the case of assignment of custody to one  
 31.21 individual in which legal or physical custody is removed from the relative custodian.  
 31.22 In the case of a relative custodian's death or incapacity, Northstar kinship assistance  
 31.23 eligibility may be continued according to subdivision 10.

31.24 Sec. 38. Minnesota Statutes 2014, section 256N.22, subdivision 10, is amended to read:

31.25 Subd. 10. **Assigning a successor relative custodian for a child's Northstar**  
 31.26 **kinship assistance to a court-appointed guardian or custodian.** (a) ~~Northstar kinship~~  
 31.27 ~~assistance may be continued with the written consent of the commissioner to~~ In the event  
 31.28 of the death or incapacity of the relative custodian, eligibility for Northstar kinship  
 31.29 assistance and title IV-E assistance, if applicable, is not affected if the relative custodian  
 31.30 is replaced by a successor named in the Northstar kinship assistance benefit agreement.  
 31.31 Northstar kinship assistance shall be paid to a named successor who is not the child's legal  
 31.32 parent, biological parent or stepparent, or other adult living in the home of the legal parent,  
 31.33 biological parent, or stepparent.

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

- 32.1 (1) meet the background study requirements in subdivision 4;  
 32.2 (2) renegotiate the agreement consistent with section 256N.25, subdivision 2,  
 32.3 including cooperating with an assessment under section 256N.24;  
 32.4 (3) be ordered by the court to be the child's legal relative custodian in a modification  
 32.5 proceeding under section 260C.521, subdivision 2; and  
 32.6 (4) satisfy the requirements in this paragraph within one year of the relative  
 32.7 custodian's death or incapacity unless the commissioner certifies that the named successor  
 32.8 made reasonable attempts to satisfy the requirements within one year and failure to satisfy  
 32.9 the requirements was not the responsibility of the named successor.
- 32.10 (c) Payment of Northstar kinship assistance to the successor guardian may be  
 32.11 temporarily approved through the policies, procedures, requirements, and deadlines under  
 32.12 section 256N.28, subdivision 2. Ongoing payment shall begin in the month when all the  
 32.13 requirements in paragraph (b) are satisfied.
- 32.14 (d) Continued payment of Northstar kinship assistance may occur in the event of the  
 32.15 death or incapacity of the relative custodian when no successor has been named in the  
 32.16 benefit agreement when the commissioner gives written consent to an individual who is a  
 32.17 guardian or custodian appointed by a court for the child upon the death of both relative  
 32.18 custodians in the case of assignment of custody to two individuals, or the sole relative  
 32.19 custodian in the case of assignment of custody to one individual, unless the child is under  
 32.20 the custody of a county, tribal, or child-placing agency.
- 32.21 ~~(b)~~ (e) Temporary assignment of Northstar kinship assistance may be approved  
 32.22 for a maximum of six consecutive months from the death or incapacity of the relative  
 32.23 custodian or custodians as provided in paragraph (a) and must adhere to the policies ~~and~~  
 32.24 procedures, requirements, and deadlines under section 256N.28, subdivision 2, that are  
 32.25 prescribed by the commissioner. If a court has not appointed a permanent legal guardian  
 32.26 or custodian within six months, the Northstar kinship assistance must terminate and must  
 32.27 not be resumed.
- 32.28 ~~(e)~~ (f) Upon assignment of assistance payments under ~~this subdivision~~ paragraphs  
 32.29 (d) and (e), assistance must be provided from funds other than title IV-E.

32.30 Sec. 39. Minnesota Statutes 2014, section 256N.24, subdivision 4, is amended to read:

32.31 Subd. 4. **Extraordinary levels.** (a) The assessment tool established under  
 32.32 subdivision 2 must provide a mechanism through which up to five levels can be added  
 32.33 to the supplemental difficulty of care for a particular child under section 256N.26,  
 32.34 subdivision 4. In establishing the assessment tool, the commissioner must design the tool



33.1 so that the levels applicable to the portions of the assessment other than the extraordinary  
33.2 levels can accommodate the requirements of this subdivision.

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

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

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

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

33.16 (4) the child is receiving the services for which the child is eligible through medical  
33.17 assistance programs or other programs that provide necessary services for children with  
33.18 disabilities or other medical and behavioral conditions to live with the child's family, but  
33.19 the agency with caregiver's input has identified a specific support gap that cannot be met  
33.20 through home and community support waivers or other programs that are designed to  
33.21 provide support for children with special needs.

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

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

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

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

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

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

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

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

34.12 Sec. 40. Minnesota Statutes 2014, section 256N.25, subdivision 1, is amended to read:

34.13 Subdivision 1. **Agreement; Northstar kinship assistance; adoption assistance.** (a)  
34.14 In order to receive Northstar kinship assistance or adoption assistance benefits on behalf  
34.15 of an eligible child, a written, binding agreement between the caregiver or caregivers,  
34.16 the financially responsible agency, or, if there is no financially responsible agency, the  
34.17 agency designated by the commissioner, and the commissioner must be established prior  
34.18 to finalization of the adoption or a transfer of permanent legal and physical custody. The  
34.19 agreement must be negotiated with the caregiver or caregivers under subdivision 2 and  
34.20 renegotiated under subdivision 3, if applicable.

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

34.23 (1) duration of the agreement;

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

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

34.27 (4) the terms of the payment, including any child care portion as specified in section  
34.28 256N.24, subdivision 3;

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

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

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

35.1 (8) the effective date of the agreement; and  
 35.2 (9) the successor relative custodian or custodians for Northstar kinship assistance,  
 35.3 when applicable. The successor relative custodian or custodians may be added or changed  
 35.4 by mutual agreement under subdivision 3.

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

35.9 (d) The effective date of the Northstar kinship assistance agreement must be the date  
 35.10 of the court order that transfers permanent legal and physical custody to the relative. The  
 35.11 effective date of the adoption assistance agreement is the date of the finalized adoption  
 35.12 decree.

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

35.15 Sec. 41. Minnesota Statutes 2014, section 256N.27, subdivision 2, is amended to read:

35.16 Subd. 2. **State share.** The commissioner shall pay the state share of the maintenance  
 35.17 payments as determined under subdivision 4, and an identical share of the pre-Northstar  
 35.18 Care foster care program under section 260C.4411, subdivision 1, the relative custody  
 35.19 assistance program under section 257.85, and the pre-Northstar Care for Children adoption  
 35.20 assistance program under chapter 259A. ~~The commissioner may transfer funds into the~~  
 35.21 ~~account if a deficit occurs.~~

35.22 Sec. 42. Minnesota Statutes 2014, section 257.0755, subdivision 1, is amended to read:

35.23 Subdivision 1. **Creation.** ~~Each ombudsperson shall operate independently from but~~  
 35.24 ~~in collaboration with the community-specific board that appointed the ombudsperson under~~  
 35.25 ~~section 257.0768: the Indian Affairs Council, the Council on Affairs of Chicano/Latino~~  
 35.26 ~~people, the Council on Black Minnesotans, and the Council on Asian-Pacific Minnesotans~~  
 35.27 The Office of Ombudspersons is organized under the Department of Human Services.

35.28 Sec. 43. Minnesota Statutes 2014, section 257.0755, subdivision 2, is amended to read:

35.29 Subd. 2. **Selection; qualifications.** The ombudsperson for each community  
 35.30 shall be selected by the applicable community-specific board established in section  
 35.31 257.0768 appointed by the governor. Each ombudsperson serves in the unclassified  
 35.32 service at the pleasure of the community-specific board governor and may be removed  
 35.33 only for just cause. Each ombudsperson must be selected without regard to political

36.1 affiliation, and shall be a person highly competent and qualified to analyze questions of  
 36.2 law, administration, and public policy regarding the protection and placement of children  
 36.3 from families of color. In addition, the ombudsperson must be experienced in dealing with  
 36.4 communities of color and knowledgeable about the needs of those communities. No  
 36.5 individual may serve as ombudsperson while holding any other public office.

36.6 Sec. 44. Minnesota Statutes 2014, section 257.0761, subdivision 1, is amended to read:

36.7 Subdivision 1. **Staff; unclassified status; retirement.** The ombudsperson for each  
 36.8 ~~group~~ community of color specified in section ~~257.0755~~ 257.076 may select, appoint, and  
 36.9 compensate out of available funds the assistants and employees as deemed necessary to  
 36.10 discharge responsibilities. All employees, except the secretarial and clerical staff, shall  
 36.11 serve at the pleasure of the ombudsperson in the unclassified service. The ombudsperson  
 36.12 and full-time staff shall be members of the Minnesota State Retirement Association.

36.13 Sec. 45. Minnesota Statutes 2014, section 257.0766, subdivision 1, is amended to read:

36.14 Subdivision 1. **Specific reports.** An ombudsperson may send conclusions and  
 36.15 suggestions concerning any matter reviewed to the governor ~~and shall provide copies of all~~  
 36.16 ~~reports to the advisory board and to the groups specified in section 257.0768, subdivision~~  
 36.17 ~~4.~~ Before making public a conclusion or recommendation that expressly or implicitly  
 36.18 criticizes an agency, facility, program, or any person, the ombudsperson shall inform the  
 36.19 governor and the affected agency, facility, program, or person concerning the conclusion  
 36.20 or recommendation. When sending a conclusion or recommendation to the governor that  
 36.21 is adverse to an agency, facility, program, or any person, the ombudsperson shall include  
 36.22 any statement of reasonable length made by that agency, facility, program, or person in  
 36.23 defense or mitigation of the ombudsperson's conclusion or recommendation.

36.24 Sec. 46. Minnesota Statutes 2014, section 257.0769, subdivision 1, is amended to read:

36.25 Subdivision 1. **Appropriations.** ~~(a) Money is appropriated from in the special fund~~  
 36.26 ~~authorized by section 256.01, subdivision 2, paragraph (o), to the Indian Affairs Council is~~  
 36.27 appropriated for the purposes of sections 257.0755 to 257.0768.

36.28 ~~(b) Money is appropriated from the special fund authorized by section 256.01,~~  
 36.29 ~~subdivision 2, paragraph (o), to the council on affairs of Chicano/Latino people for the~~  
 36.30 ~~purposes of sections 257.0755 to 257.0768.~~

36.31 ~~(c) Money is appropriated from the special fund authorized by section 256.01,~~  
 36.32 ~~subdivision 2, paragraph (o), to the Council of Black Minnesotans for the purposes of~~  
 36.33 ~~sections 257.0755 to 257.0768.~~

37.1 ~~(d) Money is appropriated from the special fund authorized by section 256.01,~~  
 37.2 ~~subdivision 2, paragraph (o), to the Council on Asian-Pacific Minnesotans for the purposes~~  
 37.3 ~~of sections 257.0755 to 257.0768.~~

37.4 Sec. 47. Minnesota Statutes 2014, section 257.75, subdivision 3, is amended to read:

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

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

37.19 (c) The recognition is:

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

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

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

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

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

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

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

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

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

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

37.34 Sec. 48. Minnesota Statutes 2014, section 257.75, subdivision 5, is amended to read:

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

38.15 (b) The form must include the following:

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

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

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

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

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

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

38.28 immediately preceding the commencement of the action;

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

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

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

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

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

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

39.6 Sec. 49. Minnesota Statutes 2014, section 259A.75, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



41.1 Sec. 50. Minnesota Statutes 2014, section 260C.007, subdivision 27, is amended to read:

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

41.9 Sec. 51. Minnesota Statutes 2014, section 260C.007, subdivision 32, is amended to read:

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

41.16 Sec. 52. Minnesota Statutes 2014, section 260C.203, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

44.3 Sec. 53. Minnesota Statutes 2014, section 260C.212, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

46.16 (iii) the child's school record;

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

46.19 (v) any other relevant educational information;

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

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

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

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

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

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

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

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

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

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

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

48.4           Sec. 54. Minnesota Statutes 2014, section 260C.212, is amended by adding a  
48.5 subdivision to read:

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

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

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

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

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

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

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

48.31           Sec. 55. Minnesota Statutes 2014, section 260C.212, is amended by adding a  
48.32 subdivision to read:

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



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

49.9 Sec. 56. Minnesota Statutes 2014, section 260C.221, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

52.16 Sec. 57. Minnesota Statutes 2014, section 260C.331, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

54.3 Sec. 58. Minnesota Statutes 2014, section 260C.451, subdivision 2, is amended to read:

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

54.12 Sec. 59. Minnesota Statutes 2014, section 260C.451, subdivision 6, is amended to read:

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

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

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

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

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

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

55.10 Sec. 60. Minnesota Statutes 2014, section 260C.515, subdivision 5, is amended to read:

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

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

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

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

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

55.25 Sec. 61. Minnesota Statutes 2014, section 260C.521, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

56.32 Sec. 62. Minnesota Statutes 2014, section 260C.521, subdivision 2, is amended to read:

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



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

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

57.11 Sec. 63. Minnesota Statutes 2014, section 260C.607, subdivision 4, is amended to read:

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

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

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

57.18 (i) placement;

57.19 (ii) visitation and contact with siblings;

57.20 (iii) visitation and contact with relatives;

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

57.22 (v) education.

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

57.28 Sec. 64. Minnesota Statutes 2014, section 290.0671, subdivision 6, is amended to read:

57.29 Subd. 6. **Appropriation.** An amount sufficient to pay the refunds required by  
 57.30 this section is appropriated to the commissioner from the general fund. ~~This amount~~  
 57.31 ~~includes any amounts appropriated to the commissioner of human services from the~~  
 57.32 ~~federal Temporary Assistance for Needy Families (TANF) block grant funds for transfer~~  
 57.33 ~~to the commissioner of revenue.~~

57.34 **EFFECTIVE DATE.** This section is effective for fiscal year 2016 and thereafter.

58.1 Sec. 65. Minnesota Statutes 2014, section 518A.26, subdivision 14, is amended to read:

58.2 Subd. 14. **Obligor.** "Obligor" means a person obligated to pay maintenance or  
58.3 support. ~~A person who has primary physical custody of a child is presumed not to be~~  
58.4 ~~an obligor for purposes of a child support order under section 518A.34, unless section~~  
58.5 ~~518A.36, subdivision 3, applies or the court makes specific written findings to overcome~~  
58.6 ~~this presumption.~~ For purposes of ordering medical support under section 518A.41, a  
58.7 parent who has primary physical custody of a child may be an obligor subject to a payment  
58.8 agreement under section 518A.69.

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

58.10 Sec. 66. Minnesota Statutes 2014, section 518A.32, subdivision 2, is amended to read:

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

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

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

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

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

58.22 Sec. 67. Minnesota Statutes 2014, section 518A.39, subdivision 1, is amended to read:

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

59.1 authority also may bring a motion for contempt of court if the obligor is in arrears in  
59.2 support or maintenance payments.

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

59.4 Sec. 68. Minnesota Statutes 2014, section 518A.39, is amended by adding a  
59.5 subdivision to read:

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

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

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

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

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

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

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

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

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

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

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

59.33 Sec. 69. Minnesota Statutes 2014, section 518A.41, subdivision 1, is amended to read:

60.1 Subdivision 1. **Definitions.** The definitions in this subdivision apply to this chapter  
60.2 and chapter 518.

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

60.6 (b) "Health carrier" means a carrier as defined in sections 62A.011, subdivision  
60.7 2, and 62L.02, subdivision 16.

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

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

60.11 (2) provided by an employer or union;

60.12 (3) purchased in the private market; or

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

60.15 Health plan includes, but is not limited to, a plan meeting the definition under section  
60.16 62A.011, subdivision 3, except that the exclusion of coverage designed solely to provide  
60.17 dental or vision care under section 62A.011, subdivision 3, clause (6), does not apply to  
60.18 the definition of health plan under this section; a group health plan governed under the  
60.19 federal Employee Retirement Income Security Act of 1974 (ERISA); a self-insured plan  
60.20 under sections 43A.23 to 43A.317 and 471.617; and a policy, contract, or certificate issued  
60.21 by a community-integrated service network licensed under chapter 62N.

60.22 (d) "Medical support" means providing health care coverage for a joint child by  
60.23 carrying health care coverage for the joint child or by contributing to the cost of health  
60.24 care coverage, public coverage, unreimbursed medical expenses, and uninsured medical  
60.25 expenses of the joint child.

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

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

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

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

61.8 Sec. 70. Minnesota Statutes 2014, section 518A.41, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

62.1 Sec. 71. Minnesota Statutes 2014, section 518A.41, subdivision 4, is amended to read:

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

62.7 (b) If a joint child is not presently enrolled in health care coverage providing medical  
62.8 benefits, upon motion of a parent or the public authority, the court must determine whether  
62.9 one or both parents have appropriate health care coverage providing medical benefits  
62.10 for the joint child.

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

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

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

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

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

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

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

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

62.31 (2) if the joint child is receiving any form of public coverage, the parent with whom  
62.32 the joint child does not reside shall contribute a monthly amount toward the actual cost of  
62.33 public coverage. The amount of the noncustodial parent's contribution is determined by  
62.34 applying the noncustodial parent's PICS to the premium ~~schedule for public coverage~~ scale  
62.35 for MinnesotaCare under section 256L.15, subdivision 2, paragraph (d). If the noncustodial  
62.36 parent's PICS meets the eligibility requirements for ~~public coverage~~ MinnesotaCare, the

63.1 contribution is the amount the noncustodial parent would pay for the child's premium. If  
 63.2 the noncustodial parent's PICS exceeds the eligibility requirements for public coverage, the  
 63.3 contribution is the amount of the premium for the highest eligible income on the appropriate  
 63.4 premium schedule for public coverage scale for MinnesotaCare under section 256L.15,  
 63.5 subdivision 2, paragraph (d). For purposes of determining the premium amount, the  
 63.6 noncustodial parent's household size is equal to one parent plus the child or children who  
 63.7 are the subject of the child support order. The custodial parent's obligation is determined  
 63.8 under the requirements for public coverage as set forth in chapter 256B ~~or 256L~~; or  
 63.9 (3) if the noncustodial parent's PICS meet the eligibility requirement for public  
 63.10 coverage under chapter 256B or the noncustodial parent receives public assistance, the  
 63.11 noncustodial parent must not be ordered to contribute toward the cost of public coverage.

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

63.14 (h) The commissioner of human services must publish a table with the premium  
 63.15 schedule for public coverage and update the chart for changes to the schedule by July  
 63.16 1 of each year.

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

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

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

63.28 Sec. 72. Minnesota Statutes 2014, section 518A.41, subdivision 14, is amended to read:

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

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

64.1 Sec. 73. Minnesota Statutes 2014, section 518A.41, subdivision 15, is amended to read:

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

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

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

64.6 (2) dental coverage;

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

64.10 (4) liabilities established under this subdivision.

64.11 (c) A party who fails to carry court-ordered dependent health care coverage is liable  
64.12 for the joint child's uninsured medical expenses unless a court order provides otherwise.

64.13 A party's failure to carry court-ordered coverage, or to provide other medical support as  
64.14 ordered, is a basis for modification of a medical support order under section 518A.39,  
64.15 subdivision 2 8, unless it meets the presumption in section 518A.39, subdivision 2.

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

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

64.21 Sec. 74. Minnesota Statutes 2014, section 518A.43, is amended by adding a  
64.22 subdivision to read:

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

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

64.29 Sec. 75. Minnesota Statutes 2014, section 518A.46, subdivision 3, is amended to read:

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

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



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

65.4 (3) other support obligations of the obligor;

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

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

65.7 (6) amounts and sources of any other earnings and income of the parties;

65.8 (7) health insurance coverage of parties;

65.9 (8) types and amounts of public assistance received by the parties, including  
65.10 Minnesota family investment plan, child care assistance, medical assistance,  
65.11 ~~MinnesotaCare~~, title IV-E foster care, or other form of assistance as defined in section  
65.12 256.741, subdivision 1; and

65.13 (9) any other information relevant to the computation of the child support obligation  
65.14 under section 518A.34.

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

65.18 (1) information pertaining to the income of the parties available to the public  
65.19 authority from the Department of Employment and Economic Development;

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

65.22 (3) a statement of the types and amount of any public assistance, as defined in  
65.23 section 256.741, subdivision 1, received by the parties; and

65.24 (4) any other information relevant to the determination of support that is known to  
65.25 the public authority and that has not been otherwise provided by the parties.

65.26 The information must be filed with the court or child support magistrate at least  
65.27 five days before any hearing involving child support, medical support, or child care  
65.28 reimbursement issues.

65.29 Sec. 76. Minnesota Statutes 2014, section 518A.46, is amended by adding a  
65.30 subdivision to read:

65.31 Subd. 3a. **Contents of pleadings for medical support modifications.** (a) In cases  
65.32 involving modification of only the medical support portion of a child support order  
65.33 under section 518A.39, subdivision 8, the initiating party shall include the following  
65.34 information, if known, in the pleadings:

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

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

66.4 (3) names and addresses of the parties' employers;

66.5 (4) gross income of the parties as stated in the order being modified;

66.6 (5) health insurance coverage of the parties; and

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

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

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

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

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

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

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

66.20 Sec. 77. Minnesota Statutes 2014, section 518A.51, is amended to read:

66.21 **518A.51 FEES FOR IV-D SERVICES.**

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

66.29 ~~(b) An application fee of \$25 shall be paid by the person who applies for child~~  
 66.30 ~~support and maintenance collection services, except persons who are receiving public~~  
 66.31 ~~assistance as defined in section 256.741 and the diversionary work program under section~~  
 66.32 ~~256J.95, persons who transfer from public assistance to nonpublic assistance status, and~~  
 66.33 ~~minor parents and parents enrolled in a public secondary school, area learning center, or~~  
 66.34 ~~alternative learning program approved by the commissioner of education.~~

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

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

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

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

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

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

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

67.35           ~~(h)~~ (g) The limitations of this section on the assessment of fees shall not apply to  
67.36 the extent inconsistent with the requirements of federal law for receiving funds for the

68.1 programs under title IV-A and title IV-D of the Social Security Act, United States Code,  
68.2 title 42, sections 601 to 613 and United States Code, title 42, sections 651 to 662.

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

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

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

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

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

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

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

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

68.24 Sec. 78. Minnesota Statutes 2014, section 518A.53, subdivision 1, is amended to read:

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

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

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

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

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

69.1 Sec. 79. Minnesota Statutes 2014, section 518A.53, subdivision 4, is amended to read:

69.2 Subd. 4. **Collection services.** (a) The commissioner of human services shall prepare  
69.3 and make available to the courts a notice of services that explains child support and  
69.4 maintenance collection services available through the public authority, including income  
69.5 withholding, and the fees for such services. Upon receiving a petition for dissolution of  
69.6 marriage or legal separation, the court administrator shall promptly send the notice of  
69.7 services to the petitioner and respondent at the addresses stated in the petition.

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

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

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

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

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

69.31 Sec. 80. Minnesota Statutes 2014, section 518A.53, subdivision 10, is amended to read:

69.32 Subd. 10. **Arrearage order.** (a) This section does not prevent the court from  
69.33 ordering the payor of funds to withhold amounts to satisfy the obligor's previous arrearage  
69.34 in support order payments. This remedy shall not operate to exclude availability of other  
69.35 remedies to enforce judgments. The employer or payor of funds shall withhold from

70.1 the obligor's income an additional amount equal to 20 percent of the monthly child  
 70.2 support or maintenance obligation until the arrearage is paid, unless the court has ordered  
 70.3 a specific monthly payback amount toward the arrears. If a support order includes a  
 70.4 specific monthly payback amount, the employer or payor of funds shall withhold from  
 70.5 the obligor's income an additional amount equal to the specific monthly payback amount  
 70.6 ordered until all arrearages are paid.

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

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

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

70.15 Sec. 81. Minnesota Statutes 2014, section 518A.60, is amended to read:

70.16 **518A.60 COLLECTION; ARREARS ONLY.**

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

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

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

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

71.1 (e) If an arrearage exists according to a support order which fails to establish a  
71.2 monthly support obligation in a specific dollar amount, the public authority, if it provides  
71.3 child support services, or the obligee, may establish a payment agreement which shall  
71.4 equal what the obligor would pay for current support after application of section 518A.34,  
71.5 plus an additional 20 percent of the current support obligation, until all arrears have been  
71.6 paid in full. If the obligor fails to enter into or comply with a payment agreement, the  
71.7 public authority, if it provides child support services, or the obligee, may move the district  
71.8 court or child support magistrate, if section 484.702 applies, for an order establishing  
71.9 repayment terms.

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

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

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

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

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

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

71.31 Sec. 82. **[518A.685] CONSUMER REPORTING AGENCY; REPORTING**  
71.32 **ARREARS.**

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

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

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

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

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

72.9 (1) pay the arrears in full; or

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

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

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

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

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

72.24 Sec. 83. Minnesota Statutes 2014, section 518C.802, is amended to read:

72.25 **518C.802 CONDITIONS OF RENDITION.**

72.26 (a) Before making demand that the governor of another state surrender an individual  
 72.27 charged criminally in this state with having failed to provide for the support of an obligee,  
 72.28 the governor of this state may require a prosecutor of this state to demonstrate that at least  
 72.29 60 days previously the obligee had initiated proceedings for support pursuant to this  
 72.30 chapter or that the proceeding would be of no avail.

72.31 (b) If, under this chapter or a law substantially similar to this chapter, ~~the Uniform~~  
 72.32 ~~Reciprocal Enforcement of Support Act, or the Revised Uniform Reciprocal Enforcement~~  
 72.33 ~~of Support Act,~~ the governor of another state makes a demand that the governor of  
 72.34 this state surrender an individual charged criminally in that state with having failed to



73.1 provide for the support of a child or other individual to whom a duty of support is owed,  
 73.2 the governor may require a prosecutor to investigate the demand and report whether  
 73.3 a proceeding for support has been initiated or would be effective. If it appears that a  
 73.4 proceeding would be effective but has not been initiated, the governor may delay honoring  
 73.5 the demand for a reasonable time to permit the initiation of a proceeding.

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

73.10 Sec. 84. Minnesota Statutes 2014, section 626.556, subdivision 1, as amended by Laws  
 73.11 2015, chapter 4, section 1, is amended to read:

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

73.21 (1) protect children and promote child safety;

73.22 (2) strengthen the family;

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

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

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

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

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

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

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

74.3 ~~(4)~~ (5) provide protective, family support, and family preservation services when  
 74.4 needed in appropriate cases.

74.5 Sec. 85. Minnesota Statutes 2014, section 626.556, subdivision 2, is amended to read:

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

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

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

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

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

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

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

74.30 (4) (3) neglect as defined in paragraph (f), clause (2), that substantially endangers  
 74.31 the child's physical or mental health, including a growth delay, which may be referred to  
 74.32 as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

74.33 (5) (4) murder in the first, second, or third degree under section 609.185, 609.19, or  
 74.34 609.195;

74.35 (6) (5) manslaughter in the first or second degree under section 609.20 or 609.205;

75.1 ~~(7)~~ (6) assault in the first, second, or third degree under section 609.221, 609.222, or  
75.2 609.223;

75.3 ~~(8)~~ (7) solicitation, inducement, and promotion of prostitution under section 609.322;

75.4 ~~(9)~~ (8) criminal sexual conduct under sections 609.342 to 609.3451;

75.5 ~~(10)~~ (9) solicitation of children to engage in sexual conduct under section 609.352;

75.6 ~~(11)~~ (10) malicious punishment or neglect or endangerment of a child under section  
75.7 609.377 or 609.378;

75.8 ~~(12)~~ (11) use of a minor in sexual performance under section 617.246; or

75.9 ~~(13)~~ (12) parental behavior, status, or condition which mandates that the county  
75.10 attorney file a termination of parental rights petition under section 260C.503, subdivision 2.

75.11 (d) "Sexual abuse" means the subjection of a child by a person responsible for the  
75.12 child's care, by a person who has a significant relationship to the child, as defined in  
75.13 section 609.341, or by a person in a position of authority, as defined in section 609.341,  
75.14 subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual  
75.15 conduct in the first degree), 609.343 (criminal sexual conduct in the second degree),  
75.16 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct  
75.17 in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual  
75.18 abuse also includes any act which involves a minor which constitutes a violation of  
75.19 prostitution offenses under sections 609.321 to 609.324 or 617.246. Sexual abuse includes  
75.20 threatened sexual abuse which includes the status of a parent or household member  
75.21 who has committed a violation which requires registration as an offender under section  
75.22 243.166, subdivision 1b, paragraph (a) or (b), or required registration under section  
75.23 243.166, subdivision 1b, paragraph (a) or (b).

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

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

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

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

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

76.9 (4) failure to ensure that the child is educated as defined in sections 120A.22 and  
76.10 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's  
76.11 child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

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

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

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

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

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

76.35 (g) "Physical abuse" means any physical injury, mental injury, or threatened injury,  
76.36 inflicted by a person responsible for the child's care on a child other than by accidental

77.1 means, or any physical or mental injury that cannot reasonably be explained by the child's  
 77.2 history of injuries, or any aversive or deprivation procedures, or regulated interventions,  
 77.3 that have not been authorized under section 125A.0942 or 245.825.

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

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

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

77.12 (3) shaking a child under age three;

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

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

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

77.17 (7) striking a child under age ~~one~~ four on the face or head;

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

77.24 (9) unreasonable physical confinement or restraint not permitted under section  
 77.25 609.379, including but not limited to tying, caging, or chaining; or

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

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

77.33 (i) "Facility" means:

77.34 (1) a licensed or unlicensed day care facility, residential facility, agency, hospital,  
 77.35 sanitarium, or other facility or institution required to be licensed under sections 144.50 to  
 77.36 144.58, 241.021, or 245A.01 to 245A.16, or chapter 245D;

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

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

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

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

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

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

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

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

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

78.23 (3) committed an act that has resulted in an involuntary termination of parental rights  
78.24 under section 260C.301, or a similar law of another jurisdiction; or

78.25 (4) committed an act that has resulted in the involuntary transfer of permanent  
78.26 legal and physical custody of a child to a relative under Minnesota Statutes 2010, section  
78.27 260C.201, subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a  
78.28 similar law of another jurisdiction.

78.29 A child is the subject of a report of threatened injury when the responsible social  
78.30 services agency receives birth match data under paragraph (o) from the Department of  
78.31 Human Services.

78.32 (o) Upon receiving data under section 144.225, subdivision 2b, contained in a  
78.33 birth record or recognition of parentage identifying a child who is subject to threatened  
78.34 injury under paragraph (n), the Department of Human Services shall send the data to the  
78.35 responsible social services agency. The data is known as "birth match" data. Unless the  
78.36 responsible social services agency has already begun an investigation or assessment of the

79.1 report due to the birth of the child or execution of the recognition of parentage and the  
79.2 parent's previous history with child protection, the agency shall accept the birth match  
79.3 data as a report under this section. The agency may use either a family assessment or  
79.4 investigation to determine whether the child is safe. All of the provisions of this section  
79.5 apply. If the child is determined to be safe, the agency shall consult with the county  
79.6 attorney to determine the appropriateness of filing a petition alleging the child is in need  
79.7 of protection or services under section 260C.007, subdivision 6, clause (16), in order to  
79.8 deliver needed services. If the child is determined not to be safe, the agency and the county  
79.9 attorney shall take appropriate action as required under section 260C.503, subdivision 2.

79.10 (p) Persons who conduct assessments or investigations under this section shall take  
79.11 into account accepted child-rearing practices of the culture in which a child participates  
79.12 and accepted teacher discipline practices, which are not injurious to the child's health,  
79.13 welfare, and safety.

79.14 (q) "Accidental" means a sudden, not reasonably foreseeable, and unexpected  
79.15 occurrence or event which:

79.16 (1) is not likely to occur and could not have been prevented by exercise of due  
79.17 care; and

79.18 (2) if occurring while a child is receiving services from a facility, happens when the  
79.19 facility and the employee or person providing services in the facility are in compliance  
79.20 with the laws and rules relevant to the occurrence or event.

79.21 (r) "Nonmaltreatment mistake" means:

79.22 (1) at the time of the incident, the individual was performing duties identified in the  
79.23 center's child care program plan required under Minnesota Rules, part 9503.0045;

79.24 (2) the individual has not been determined responsible for a similar incident that  
79.25 resulted in a finding of maltreatment for at least seven years;

79.26 (3) the individual has not been determined to have committed a similar  
79.27 nonmaltreatment mistake under this paragraph for at least four years;

79.28 (4) any injury to a child resulting from the incident, if treated, is treated only with  
79.29 remedies that are available over the counter, whether ordered by a medical professional or  
79.30 not; and

79.31 (5) except for the period when the incident occurred, the facility and the individual  
79.32 providing services were both in compliance with all licensing requirements relevant to the  
79.33 incident.

79.34 This definition only applies to child care centers licensed under Minnesota  
79.35 Rules, chapter 9503. If clauses (1) to (5) apply, rather than making a determination of

80.1 substantiated maltreatment by the individual, the commissioner of human services shall  
80.2 determine that a nonmaltreatment mistake was made by the individual.

80.3 Sec. 86. Minnesota Statutes 2014, section 626.556, subdivision 3, is amended to read:

80.4 Subd. 3. **Persons mandated to report; persons voluntarily reporting.** (a) A  
80.5 person who knows or has reason to believe a child is being neglected or physically or  
80.6 sexually abused, as defined in subdivision 2, or has been neglected or physically or  
80.7 sexually abused within the preceding three years, shall immediately report the information  
80.8 to the local welfare agency, agency responsible for assessing or investigating the report,  
80.9 police department, or the county sheriff if the person is:

80.10 (1) a professional or professional's delegate who is engaged in the practice of  
80.11 the healing arts, social services, hospital administration, psychological or psychiatric  
80.12 treatment, child care, education, correctional supervision, probation and correctional  
80.13 services, or law enforcement; or

80.14 (2) employed as a member of the clergy and received the information while  
80.15 engaged in ministerial duties, provided that a member of the clergy is not required by  
80.16 this subdivision to report information that is otherwise privileged under section 595.02,  
80.17 subdivision 1, paragraph (c).

80.18 ~~The police department or the county sheriff, upon receiving a report, shall~~  
80.19 ~~immediately notify the local welfare agency or agency responsible for assessing or~~  
80.20 ~~investigating the report, orally and in writing. The local welfare agency, or agency~~  
80.21 ~~responsible for assessing or investigating the report, upon receiving a report, shall~~  
80.22 ~~immediately notify the local police department or the county sheriff orally and in writing.~~  
80.23 ~~The county sheriff and the head of every local welfare agency, agency responsible~~  
80.24 ~~for assessing or investigating reports, and police department shall each designate a~~  
80.25 ~~person within their agency, department, or office who is responsible for ensuring that~~  
80.26 ~~the notification duties of this paragraph and paragraph (b) are carried out. Nothing in~~  
80.27 ~~this subdivision shall be construed to require more than one report from any institution,~~  
80.28 ~~facility, school, or agency.~~

80.29 (b) Any person may voluntarily report to the local welfare agency, agency responsible  
80.30 for assessing or investigating the report, police department, or the county sheriff if the  
80.31 person knows, has reason to believe, or suspects a child is being or has been neglected or  
80.32 subjected to physical or sexual abuse. ~~The police department or the county sheriff, upon~~  
80.33 ~~receiving a report, shall immediately notify the local welfare agency or agency responsible~~  
80.34 ~~for assessing or investigating the report, orally and in writing. The local welfare agency or~~



81.1 ~~agency responsible for assessing or investigating the report, upon receiving a report, shall~~  
81.2 ~~immediately notify the local police department or the county sheriff orally and in writing.~~

81.3 (c) A person mandated to report physical or sexual child abuse or neglect occurring  
81.4 within a licensed facility shall report the information to the agency responsible for  
81.5 licensing the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or  
81.6 chapter 245D; or a nonlicensed personal care provider organization as defined in section  
81.7 256B.0625, subdivision 19. A health or corrections agency receiving a report may request  
81.8 the local welfare agency to provide assistance pursuant to subdivisions 10, 10a, and 10b. A  
81.9 board or other entity whose licensees perform work within a school facility, upon receiving  
81.10 a complaint of alleged maltreatment, shall provide information about the circumstances of  
81.11 the alleged maltreatment to the commissioner of education. Section 13.03, subdivision 4,  
81.12 applies to data received by the commissioner of education from a licensing entity.

81.13 (d) ~~Any person mandated to report shall receive a summary of the disposition of~~  
81.14 ~~any report made by that reporter, including whether the case has been opened for child~~  
81.15 ~~protection or other services, or if a referral has been made to a community organization,~~  
81.16 ~~unless release would be detrimental to the best interests of the child. Any person who is~~  
81.17 ~~not mandated to report shall, upon request to the local welfare agency, receive a concise~~  
81.18 ~~summary of the disposition of any report made by that reporter, unless release would be~~  
81.19 ~~detrimental to the best interests of the child. Notification requirements under subdivision~~  
81.20 10 apply to all reports received under this section.

81.21 (e) For purposes of this section, "immediately" means as soon as possible but in  
81.22 no event longer than 24 hours.

81.23 Sec. 87. Minnesota Statutes 2014, section 626.556, subdivision 6a, is amended to read:

81.24 Subd. 6a. **Failure to notify.** If a local welfare agency receives a report under  
81.25 subdivision 3, paragraph (a) or (b), and fails to notify the local police department or county  
81.26 sheriff as required by subdivision 3, ~~paragraph (a) or (b)~~ 10, the person within the agency  
81.27 who is responsible for ensuring that notification is made shall be subject to disciplinary  
81.28 action in keeping with the agency's existing policy or collective bargaining agreement on  
81.29 discipline of employees. If a local police department or a county sheriff receives a report  
81.30 under subdivision 3, paragraph (a) or (b), and fails to notify the local welfare agency as  
81.31 required by subdivision 3, ~~paragraph (a) or (b)~~ 10, the person within the police department  
81.32 or county sheriff's office who is responsible for ensuring that notification is made shall be  
81.33 subject to disciplinary action in keeping with the agency's existing policy or collective  
81.34 bargaining agreement on discipline of employees.

82.1 Sec. 88. Minnesota Statutes 2014, section 626.556, subdivision 7, as amended by Laws  
82.2 2015, chapter 4, section 2, is amended to read:

82.3 Subd. 7. **Report; information provided to parent; reporter.** (a) An oral report  
82.4 shall be made immediately by telephone or otherwise. An oral report made by a person  
82.5 required under subdivision 3 to report shall be followed within 72 hours, exclusive  
82.6 of weekends and holidays, by a report in writing to the appropriate police department,  
82.7 the county sheriff, the agency responsible for assessing or investigating the report, or  
82.8 the local welfare agency.

82.9 (b) The local welfare agency shall determine if the report is ~~accepted for an~~  
82.10 ~~assessment or investigation~~ to be screened in or out as soon as possible but in no event  
82.11 longer than 24 hours after the report is received. When determining whether a report will  
82.12 be screened in or out, the agency receiving the report must consider, when relevant, all  
82.13 previous history, including reports that were screened out. The agency may communicate  
82.14 with treating professionals and individuals specified under subdivision 10, paragraph  
82.15 (i), clause (3), item (iii).

82.16 ~~(b)~~ (c) Any report shall be of sufficient content to identify the child, any person  
82.17 believed to be responsible for the abuse or neglect of the child if the person is known, the  
82.18 nature and extent of the abuse or neglect and the name and address of the reporter. The  
82.19 local welfare agency or agency responsible for assessing or investigating the report shall  
82.20 accept a report made under subdivision 3 notwithstanding refusal by a reporter to provide  
82.21 the reporter's name or address as long as the report is otherwise sufficient under this  
82.22 paragraph. Written reports received by a police department or the county sheriff shall be  
82.23 forwarded immediately to the local welfare agency or the agency responsible for assessing  
82.24 or investigating the report. The police department or the county sheriff may keep copies of  
82.25 reports received by them. Copies of written reports received by a local welfare department  
82.26 or the agency responsible for assessing or investigating the report shall be forwarded  
82.27 immediately to the local police department or the county sheriff.

82.28 ~~(e)~~ (d) When requested, the agency responsible for assessing or investigating a  
82.29 report shall inform the reporter within ten days after the report was made, either orally or  
82.30 in writing, whether the report was accepted or not. If the responsible agency determines  
82.31 the report does not constitute a report under this section, the agency shall advise the  
82.32 reporter the report was screened out. Any person mandated to report shall receive a  
82.33 summary of the disposition of any report made by that reporter, including whether the case  
82.34 has been opened for child protection or other services, or if a referral has been made to a  
82.35 community organization, unless release would be detrimental to the best interests of the  
82.36 child. Any person who is not mandated to report shall, upon request to the local welfare

83.1 agency, receive a concise summary of the disposition of any report made by that reporter,  
 83.2 unless release would be detrimental to the best interests of the child.

83.3 (e) Reports that are not screened in must be maintained in accordance with  
 83.4 subdivision 11c, paragraph (a).

83.5 ~~(d)~~ (f) Notwithstanding paragraph (a), the commissioner of education must inform  
 83.6 the parent, guardian, or legal custodian of the child who is the subject of a report of  
 83.7 alleged maltreatment in a school facility within ten days of receiving the report, either  
 83.8 orally or in writing, whether the commissioner is assessing or investigating the report  
 83.9 of alleged maltreatment.

83.10 ~~(e)~~ (g) Regardless of whether a report is made under this subdivision, as soon as  
 83.11 practicable after a school receives information regarding an incident that may constitute  
 83.12 maltreatment of a child in a school facility, the school shall inform the parent, legal  
 83.13 guardian, or custodian of the child that an incident has occurred that may constitute  
 83.14 maltreatment of the child, when the incident occurred, and the nature of the conduct  
 83.15 that may constitute maltreatment.

83.16 ~~(f)~~ (h) A written copy of a report maintained by personnel of agencies, other than  
 83.17 welfare or law enforcement agencies, which are subject to chapter 13 shall be confidential.  
 83.18 An individual subject of the report may obtain access to the original report as provided  
 83.19 by subdivision 11.

83.20 Sec. 89. Minnesota Statutes 2014, section 626.556, is amended by adding a subdivision  
 83.21 to read:

83.22 Subd. 7a. **Mandatory guidance for screening reports.** (a) Child protection intake  
 83.23 workers, supervisors, and others involved with child protection screening shall, at a  
 83.24 minimum, follow the guidance provided in the Minnesota Child Maltreatment Screening  
 83.25 Guidelines when screening reports and, when notified by the commissioner of human  
 83.26 services, shall immediately implement updated procedures and protocols.

83.27 (b) Any modifications to the screening guidelines by the county agency must be  
 83.28 preapproved by the commissioner of human services and must not be less protective of  
 83.29 children than is mandated by statute. The guidelines may provide additional protections  
 83.30 for children but must not limit reports that are screened in or provide additional limits on  
 83.31 consideration of reports that were screened out in making screening determinations.

83.32 Sec. 90. Minnesota Statutes 2014, section 626.556, subdivision 10, is amended to read:

83.33 Subd. 10. **Duties of local welfare agency and local law enforcement agency upon**  
 83.34 **receipt of report; mandatory notification between police or sheriff and agency.** (a)

84.1 The police department or the county sheriff shall immediately notify the local welfare  
84.2 agency or agency responsible for child protection reports under this section orally and  
84.3 in writing when a report is received. The local welfare agency or agency responsible for  
84.4 child protection reports shall immediately notify the local police department or the county  
84.5 sheriff orally and in writing when a report is received. The county sheriff and the head of  
84.6 every local welfare agency, agency responsible for child protection reports, and police  
84.7 department shall each designate a person within their agency, department, or office who is  
84.8 responsible for ensuring that the notification duties of this paragraph are carried out.

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

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

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

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

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

84.26 If the report alleges neglect, physical abuse, or sexual abuse by a parent, guardian,  
84.27 or individual functioning within the family unit as a person responsible for the child's  
84.28 care, or sexual abuse by a person with a significant relationship to the child when that  
84.29 person resides in the child's household or by a sibling, the local welfare agency shall  
84.30 immediately conduct a family assessment or investigation as identified in clauses (1)  
84.31 to (4). In conducting a family assessment or investigation, the local welfare agency  
84.32 shall gather information on the existence of substance abuse and domestic violence and  
84.33 offer services for purposes of preventing future child maltreatment, safeguarding and  
84.34 enhancing the welfare of the abused or neglected minor, and supporting and preserving  
84.35 family life whenever possible. If the report alleges a violation of a criminal statute  
84.36 involving sexual abuse, physical abuse, or neglect or endangerment, under section

85.1 609.378, the local law enforcement agency and local welfare agency shall coordinate the  
85.2 planning and execution of their respective investigation and assessment efforts to avoid a  
85.3 duplication of fact-finding efforts and multiple interviews. Each agency shall prepare a  
85.4 separate report of the results of its investigation or assessment. In cases of alleged child  
85.5 maltreatment resulting in death, the local agency may rely on the fact-finding efforts of a  
85.6 law enforcement investigation to make a determination of whether or not maltreatment  
85.7 occurred. When necessary the local welfare agency shall seek authority to remove the  
85.8 child from the custody of a parent, guardian, or adult with whom the child is living. In  
85.9 performing any of these duties, the local welfare agency shall maintain appropriate records.

85.10 If the family assessment or investigation indicates there is a potential for abuse of  
85.11 alcohol or other drugs by the parent, guardian, or person responsible for the child's care,  
85.12 the local welfare agency shall conduct a chemical use assessment pursuant to Minnesota  
85.13 Rules, part 9530.6615.

85.14 ~~(b)~~ (c) When a local agency receives a report or otherwise has information indicating  
85.15 that a child who is a client, as defined in section 245.91, has been the subject of physical  
85.16 abuse, sexual abuse, or neglect at an agency, facility, or program as defined in section  
85.17 245.91, it shall, in addition to its other duties under this section, immediately inform the  
85.18 ombudsman established under sections 245.91 to 245.97. The commissioner of education  
85.19 shall inform the ombudsman established under sections 245.91 to 245.97 of reports  
85.20 regarding a child defined as a client in section 245.91 that maltreatment occurred at a  
85.21 school as defined in sections 120A.05, subdivisions 9, 11, and 13, and 124D.10.

85.22 ~~(e)~~ (d) Authority of the local welfare agency responsible for assessing or  
85.23 investigating the child abuse or neglect report, the agency responsible for assessing or  
85.24 investigating the report, and of the local law enforcement agency for investigating the  
85.25 alleged abuse or neglect includes, but is not limited to, authority to interview, without  
85.26 parental consent, the alleged victim and any other minors who currently reside with or  
85.27 who have resided with the alleged offender. The interview may take place at school or at  
85.28 any facility or other place where the alleged victim or other minors might be found or the  
85.29 child may be transported to, and the interview conducted at, a place appropriate for the  
85.30 interview of a child designated by the local welfare agency or law enforcement agency.  
85.31 The interview may take place outside the presence of the alleged offender or parent, legal  
85.32 custodian, guardian, or school official. For family assessments, it is the preferred practice  
85.33 to request a parent or guardian's permission to interview the child prior to conducting the  
85.34 child interview, unless doing so would compromise the safety assessment. Except as  
85.35 provided in this paragraph, the parent, legal custodian, or guardian shall be notified by  
85.36 the responsible local welfare or law enforcement agency no later than the conclusion of

86.1 the investigation or assessment that this interview has occurred. Notwithstanding rule 32  
86.2 of the Minnesota Rules of Procedure for Juvenile Courts, the juvenile court may, after  
86.3 hearing on an ex parte motion by the local welfare agency, order that, where reasonable  
86.4 cause exists, the agency withhold notification of this interview from the parent, legal  
86.5 custodian, or guardian. If the interview took place or is to take place on school property,  
86.6 the order shall specify that school officials may not disclose to the parent, legal custodian,  
86.7 or guardian the contents of the notification of intent to interview the child on school  
86.8 property, as provided under this paragraph, and any other related information regarding  
86.9 the interview that may be a part of the child's school record. A copy of the order shall be  
86.10 sent by the local welfare or law enforcement agency to the appropriate school official.

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

86.27 Except where the alleged offender is believed to be a school official or employee,  
86.28 the time and place, and manner of the interview on school premises shall be within the  
86.29 discretion of school officials, but the local welfare or law enforcement agency shall have  
86.30 the exclusive authority to determine who may attend the interview. The conditions as to  
86.31 time, place, and manner of the interview set by the school officials shall be reasonable and  
86.32 the interview shall be conducted not more than 24 hours after the receipt of the notification  
86.33 unless another time is considered necessary by agreement between the school officials and  
86.34 the local welfare or law enforcement agency. Where the school fails to comply with the  
86.35 provisions of this paragraph, the juvenile court may order the school to comply. Every

87.1 effort must be made to reduce the disruption of the educational program of the child, other  
87.2 students, or school staff when an interview is conducted on school premises.

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

87.9 ~~(f)~~ (g) Before making an order under paragraph ~~(e)~~ (f), the court shall issue an order  
87.10 to show cause, either upon its own motion or upon a verified petition, specifying the basis  
87.11 for the requested interviews and fixing the time and place of the hearing. The order to  
87.12 show cause shall be served personally and shall be heard in the same manner as provided  
87.13 in other cases in the juvenile court. The court shall consider the need for appointment of a  
87.14 guardian ad litem to protect the best interests of the child. If appointed, the guardian ad  
87.15 litem shall be present at the hearing on the order to show cause.

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

87.25 ~~(h)~~ (i) The local welfare agency responsible for conducting a family assessment or  
87.26 investigation shall collect available and relevant information to determine child safety,  
87.27 risk of subsequent child maltreatment, and family strengths and needs and share not public  
87.28 information with an Indian's tribal social services agency without violating any law of the  
87.29 state that may otherwise impose duties of confidentiality on the local welfare agency in  
87.30 order to implement the tribal state agreement. The local welfare agency or the agency  
87.31 responsible for investigating the report shall collect available and relevant information  
87.32 to ascertain whether maltreatment occurred and whether protective services are needed.  
87.33 Information collected includes, when relevant, information with regard to the person  
87.34 reporting the alleged maltreatment, including the nature of the reporter's relationship to the  
87.35 child and to the alleged offender, and the basis of the reporter's knowledge for the report;  
87.36 the child allegedly being maltreated; the alleged offender; the child's caretaker; and other

88.1 collateral sources having relevant information related to the alleged maltreatment. The  
88.2 local welfare agency or the agency responsible for investigating the report may make a  
88.3 determination of no maltreatment early in an investigation, and close the case and retain  
88.4 immunity, if the collected information shows no basis for a full investigation.

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

88.7 (1) the child's sex and age, prior reports of maltreatment, information relating  
88.8 to developmental functioning, credibility of the child's statement, and whether the  
88.9 information provided under this clause is consistent with other information collected  
88.10 during the course of the assessment or investigation;

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

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

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

88.26 Nothing in this paragraph precludes the local welfare agency, the local law  
88.27 enforcement agency, or the agency responsible for assessing or investigating the report  
88.28 from collecting other relevant information necessary to conduct the assessment or  
88.29 investigation. Notwithstanding sections 13.384 or 144.291 to 144.298, the local welfare  
88.30 agency has access to medical data and records for purposes of clause (3). Notwithstanding  
88.31 the data's classification in the possession of any other agency, data acquired by the  
88.32 local welfare agency or the agency responsible for assessing or investigating the report  
88.33 during the course of the assessment or investigation are private data on individuals and  
88.34 must be maintained in accordance with subdivision 11. Data of the commissioner of  
88.35 education collected or maintained during and for the purpose of an investigation of



89.1 alleged maltreatment in a school are governed by this section, notwithstanding the data's  
89.2 classification as educational, licensing, or personnel data under chapter 13.

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

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

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

- 89.24 (1) audio recordings of all interviews with witnesses and collateral sources; and  
89.25 (2) in cases of alleged sexual abuse, audio-video recordings of each interview with  
89.26 the alleged victim and child witnesses.

89.27 ~~(k)~~ (l) In conducting an assessment or investigation involving a school facility  
89.28 as defined in subdivision 2, paragraph (i), the commissioner of education shall collect  
89.29 available and relevant information and use the procedures in paragraphs ~~(i)~~ (j), (k), and  
89.30 subdivision 3d, except that the requirement for face-to-face observation of the child  
89.31 and face-to-face interview of the alleged offender is to occur in the initial stages of the  
89.32 assessment or investigation provided that the commissioner may also base the assessment  
89.33 or investigation on investigative reports and data received from the school facility and  
89.34 local law enforcement, to the extent those investigations satisfy the requirements of  
89.35 paragraphs ~~(i)~~ and (j), (k), and subdivision 3d.

90.1 Sec. 91. Minnesota Statutes 2014, section 626.556, subdivision 10e, is amended to read:

90.2 Subd. 10e. **Determinations.** (a) The local welfare agency shall conclude the family  
90.3 assessment or the investigation within 45 days of the receipt of a report. The conclusion of  
90.4 the assessment or investigation may be extended to permit the completion of a criminal  
90.5 investigation or the receipt of expert information requested within 45 days of the receipt  
90.6 of the report.

90.7 (b) After conducting a family assessment, the local welfare agency shall determine  
90.8 whether services are needed to address the safety of the child and other family members  
90.9 and the risk of subsequent maltreatment.

90.10 (c) After conducting an investigation, the local welfare agency shall make two  
90.11 determinations: first, whether maltreatment has occurred; and second, whether child  
90.12 protective services are needed. No determination of maltreatment shall be made when the  
90.13 alleged perpetrator is a child under the age of ten.

90.14 (d) If the commissioner of education conducts an assessment or investigation,  
90.15 the commissioner shall determine whether maltreatment occurred and what corrective  
90.16 or protective action was taken by the school facility. If a determination is made that  
90.17 maltreatment has occurred, the commissioner shall report to the employer, the school  
90.18 board, and any appropriate licensing entity the determination that maltreatment occurred  
90.19 and what corrective or protective action was taken by the school facility. In all other cases,  
90.20 the commissioner shall inform the school board or employer that a report was received,  
90.21 the subject of the report, the date of the initial report, the category of maltreatment alleged  
90.22 as defined in paragraph (f), the fact that maltreatment was not determined, and a summary  
90.23 of the specific reasons for the determination.

90.24 (e) When maltreatment is determined in an investigation involving a facility,  
90.25 the investigating agency shall also determine whether the facility or individual was  
90.26 responsible, or whether both the facility and the individual were responsible for the  
90.27 maltreatment using the mitigating factors in paragraph (i). Determinations under this  
90.28 subdivision must be made based on a preponderance of the evidence and are private data  
90.29 on individuals or nonpublic data as maintained by the commissioner of education.

90.30 (f) For the purposes of this subdivision, "maltreatment" means any of the following  
90.31 acts or omissions:

- 90.32 (1) physical abuse as defined in subdivision 2, paragraph (g);  
90.33 (2) neglect as defined in subdivision 2, paragraph (f);  
90.34 (3) sexual abuse as defined in subdivision 2, paragraph (d);  
90.35 (4) mental injury as defined in subdivision 2, paragraph (m); or  
90.36 (5) maltreatment of a child in a facility as defined in subdivision 2, paragraph (i).

91.1 (g) For the purposes of this subdivision, a determination that child protective  
91.2 services are needed means that the local welfare agency has documented conditions  
91.3 during the assessment or investigation sufficient to cause a child protection worker, as  
91.4 defined in section 626.559, subdivision 1, to conclude that a child is at significant risk of  
91.5 maltreatment if protective intervention is not provided and that the individuals responsible  
91.6 for the child's care have not taken or are not likely to take actions to protect the child  
91.7 from maltreatment or risk of maltreatment.

91.8 (h) This subdivision does not mean that maltreatment has occurred solely because  
91.9 the child's parent, guardian, or other person responsible for the child's care in good faith  
91.10 selects and depends upon spiritual means or prayer for treatment or care of disease  
91.11 or remedial care of the child, in lieu of medical care. However, if lack of medical care  
91.12 may result in serious danger to the child's health, the local welfare agency may ensure  
91.13 that necessary medical services are provided to the child.

91.14 (i) When determining whether the facility or individual is the responsible party, or  
91.15 whether both the facility and the individual are responsible for determined maltreatment in  
91.16 a facility, the investigating agency shall consider at least the following mitigating factors:

91.17 (1) whether the actions of the facility or the individual caregivers were according to,  
91.18 and followed the terms of, an erroneous physician order, prescription, individual care plan,  
91.19 or directive; however, this is not a mitigating factor when the facility or caregiver was  
91.20 responsible for the issuance of the erroneous order, prescription, individual care plan, or  
91.21 directive or knew or should have known of the errors and took no reasonable measures to  
91.22 correct the defect before administering care;

91.23 (2) comparative responsibility between the facility, other caregivers, and  
91.24 requirements placed upon an employee, including the facility's compliance with related  
91.25 regulatory standards and the adequacy of facility policies and procedures, facility training,  
91.26 an individual's participation in the training, the caregiver's supervision, and facility staffing  
91.27 levels and the scope of the individual employee's authority and discretion; and

91.28 (3) whether the facility or individual followed professional standards in exercising  
91.29 professional judgment.

91.30 The evaluation of the facility's responsibility under clause (2) must not be based on the  
91.31 completeness of the risk assessment or risk reduction plan required under section 245A.66,  
91.32 but must be based on the facility's compliance with the regulatory standards for policies and  
91.33 procedures, training, and supervision as cited in Minnesota Statutes and Minnesota Rules.

91.34 (j) Notwithstanding paragraph (i), when maltreatment is determined to have been  
91.35 committed by an individual who is also the facility license holder, both the individual and  
91.36 the facility must be determined responsible for the maltreatment, and both the background

92.1 study disqualification standards under section 245C.15, subdivision 4, and the licensing  
 92.2 actions under sections 245A.06 or 245A.07 apply.

92.3 ~~(k) Individual counties may implement more detailed definitions or criteria that~~  
 92.4 ~~indicate which allegations to investigate, as long as a county's policies are consistent~~  
 92.5 ~~with the definitions in the statutes and rules and are approved by the county board. Each~~  
 92.6 ~~local welfare agency shall periodically inform mandated reporters under subdivision 3~~  
 92.7 ~~who work in the county of the definitions of maltreatment in the statutes and rules and any~~  
 92.8 ~~additional definitions or criteria that have been approved by the county board.~~

92.9 Sec. 92. Minnesota Statutes 2014, section 626.556, subdivision 10j, is amended to read:

92.10 Subd. 10j. **Release of data to mandated reporters.** (a) A local social services or  
 92.11 child protection agency, or the agency responsible for assessing or investigating the report  
 92.12 of maltreatment, ~~may~~ shall provide relevant private data on individuals obtained under  
 92.13 this section to a mandated reporters reporter who made the report and who have has an  
 92.14 ongoing responsibility for the health, education, or welfare of a child affected by the data,  
 92.15 unless the agency determines that providing the data would not be in the best interests  
 92.16 of the child. The agency may provide the data to other mandated reporters with ongoing  
 92.17 responsibility for the health, education, or welfare of the child. Mandated reporters with  
 92.18 ongoing responsibility for the health, education, or welfare of a child affected by the data  
 92.19 include the child's teachers or other appropriate school personnel, foster parents, health  
 92.20 care providers, respite care workers, therapists, social workers, child care providers,  
 92.21 residential care staff, crisis nursery staff, probation officers, and court services personnel.  
 92.22 Under this section, a mandated reporter need not have made the report to be considered a  
 92.23 person with ongoing responsibility for the health, education, or welfare of a child affected  
 92.24 by the data. Data provided under this section must be limited to data pertinent to the  
 92.25 individual's responsibility for caring for the child.

92.26 (b) A reporter who receives private data on individuals under this subdivision must  
 92.27 treat the data according to that classification, regardless of whether the reporter is an  
 92.28 employee of a government entity. The remedies and penalties under sections 13.08 and  
 92.29 13.09 apply if a reporter releases data in violation of this section or other law.

92.30 Sec. 93. Minnesota Statutes 2014, section 626.556, subdivision 10m, is amended to  
 92.31 read:

92.32 Subd. 10m. **Provision of child protective services; consultation with county**  
 92.33 **attorney.** (a) The local welfare agency shall create a written plan, in collaboration with  
 92.34 the family whenever possible, within 30 days of the determination that child protective

93.1 services are needed or upon joint agreement of the local welfare agency and the family  
93.2 that family support and preservation services are needed. Child protective services for a  
93.3 family are voluntary unless ordered by the court.

93.4 (b) The local welfare agency shall consult with the county attorney to determine the  
93.5 appropriateness of filing a petition alleging the child is in need of protection or services  
93.6 under section 260C.007, subdivision 6, if:

93.7 (1) the family does not accept or comply with a plan for child protective services;

93.8 (2) voluntary child protective services may not provide sufficient protection for the  
93.9 child; or

93.10 (3) the family is not cooperating with an investigation.

93.11 If the agency responsible for child protection under this section is an Indian tribe  
93.12 social service agency, the agency shall consult with the tribal authority that would be  
93.13 responsible for filing a petition.

93.14 Sec. 94. Minnesota Statutes 2014, section 626.556, subdivision 11c, is amended to read:

93.15 Subd. 11c. **Welfare, court services agency, and school records maintained;**  
93.16 **county duty to maintain reports.** Notwithstanding sections 138.163 and 138.17,  
93.17 records maintained or records derived from reports of abuse by local welfare agencies,  
93.18 agencies responsible for assessing or investigating the report, court services agencies, or  
93.19 schools under this section shall be destroyed as provided in paragraphs (a) to ~~(d)~~ (e) by  
93.20 the responsible authority.

93.21 (a) For reports that were not screened in, family assessment cases, and cases  
93.22 where an investigation results in no determination of maltreatment or the need for child  
93.23 protective services, the assessment or investigation records must be maintained by the  
93.24 local welfare agency for a period of ~~four~~ five years after the date of the final entry in the  
93.25 case record. Records under this paragraph may not be used for employment, background  
93.26 checks, or purposes other than to assist in future risk and safety assessments.

93.27 (b) All records relating to reports which, upon investigation, indicate either  
93.28 maltreatment or a need for child protective services shall be maintained for ten years after  
93.29 the date of the final entry in the case record.

93.30 (c) All records regarding a report of maltreatment, including any notification of  
93.31 intent to interview which was received by a school under subdivision 10, paragraph ~~(d)~~  
93.32 (e), shall be destroyed by the school when ordered to do so by the agency conducting the  
93.33 assessment or investigation. The agency shall order the destruction of the notification  
93.34 when other records relating to the report under investigation or assessment are destroyed  
93.35 under this subdivision.

94.1 (d) Private or confidential data released to a court services agency under subdivision  
 94.2 10h must be destroyed by the court services agency when ordered to do so by the local  
 94.3 welfare agency that released the data. The local welfare agency or agency responsible for  
 94.4 assessing or investigating the report shall order destruction of the data when other records  
 94.5 relating to the assessment or investigation are destroyed under this subdivision.

94.6 (e) For reports alleging child maltreatment that were not accepted for assessment  
 94.7 or investigation, counties shall:

94.8 (1) maintain sufficient information to identify repeat reports alleging maltreatment  
 94.9 of the same child or children for 365 days five years from the date the report was screened  
 94.10 out, and the commissioner of human services shall specify to the counties the minimum  
 94.11 information needed to accomplish this purpose. Counties shall;

94.12 (2) document the reason as to why the report was not accepted for assessment or  
 94.13 investigation; and

94.14 (3) enter this the data under clauses (1) and (2) into the state social services  
 94.15 information system.

94.16 Sec. 95. Minnesota Statutes 2014, section 626.556, is amended by adding a subdivision  
 94.17 to read:

94.18 **Subd. 16. Commissioner's duty to provide oversight; quality assurance reviews;**  
 94.19 **annual summary results of reviews.** (a) The commissioner shall develop a plan to  
 94.20 perform quality assurance reviews of county agency screening practices and decisions.  
 94.21 The commissioner shall, during quality assurance reviews of county agency screening  
 94.22 practices, assess for evidence that the screening practices and decisions have followed the  
 94.23 guidelines for cultural competence issued by the Department of Human Services. The  
 94.24 commissioner shall provide oversight and guidance to counties to ensure the consistent  
 94.25 application of screening guidelines, thorough and appropriate screening decisions, and  
 94.26 correct documentation and maintenance of reports.

94.27 (b) The commissioner shall produce an annual report of the summary results of  
 94.28 the reviews. The report is public information and must be provided to the chairs and  
 94.29 ranking minority members of the legislative committees having jurisdiction over child  
 94.30 protection issues.

94.31 Sec. 96. Laws 2014, chapter 189, section 5, is amended to read:

94.32 Sec. 5. Minnesota Statutes 2012, section 518C.201, is amended to read:

94.33 **518C.201 BASES FOR JURISDICTION OVER NONRESIDENT.**

95.1 (a) In a proceeding to establish, or enforce, ~~or modify~~ a support order or to determine  
 95.2 parentage of a child, a tribunal of this state may exercise personal jurisdiction over a  
 95.3 nonresident individual or the individual's guardian or conservator if:

95.4 (1) the individual is personally served with a summons or comparable document  
 95.5 within this state;

95.6 (2) the individual submits to the jurisdiction of this state by consent, by entering a  
 95.7 general appearance, or by filing a responsive document having the effect of waiving any  
 95.8 contest to personal jurisdiction;

95.9 (3) the individual resided with the child in this state;

95.10 (4) the individual resided in this state and provided prenatal expenses or support  
 95.11 for the child;

95.12 (5) the child resides in this state as a result of the acts or directives of the individual;

95.13 (6) the individual engaged in sexual intercourse in this state and the child may have  
 95.14 been conceived by that act of intercourse;

95.15 (7) the individual asserted parentage of a child under sections 257.51 to 257.75; or

95.16 (8) there is any other basis consistent with the constitutions of this state and the  
 95.17 United States for the exercise of personal jurisdiction.

95.18 (b) The bases of personal jurisdiction in paragraph (a) or in any other law of this state  
 95.19 may not be used to acquire personal jurisdiction for a tribunal of this state to modify a child  
 95.20 support order of another state unless the requirements of section 518C.611 are met, or, in  
 95.21 the case of a foreign support order, unless the requirements of section 518C.615 are met.

95.22 Sec. 97. Laws 2014, chapter 189, section 10, is amended to read:

95.23 Sec. 10. Minnesota Statutes 2012, section 518C.206, is amended to read:

95.24 **~~518C.206 ENFORCEMENT AND MODIFICATION OF SUPPORT ORDER~~**  
 95.25 **~~BY TRIBUNAL HAVING CONTINUING JURISDICTION TO ENFORCE CHILD~~**  
 95.26 **SUPPORT ORDER.**

95.27 (a) A tribunal of this state that has issued a child support order consistent with the  
 95.28 law of this state may serve as an initiating tribunal to request a tribunal of another state  
 95.29 to enforce:

95.30 (1) the order if the order is the controlling order and has not been modified by  
 95.31 a tribunal of another state that assumed jurisdiction pursuant to ~~this chapter or a law~~  
 95.32 ~~substantially similar to this chapter~~ the Uniform Interstate Family Support Act; or

95.33 (2) a money judgment for arrears of support and interest on the order accrued before  
 95.34 a determination that an order of a tribunal of another state is the controlling order.

96.1 (b) A tribunal of this state having continuing, ~~exclusive~~ jurisdiction over a support  
 96.2 order may act as a responding tribunal to enforce the order.

96.3 Sec. 98. Laws 2014, chapter 189, section 11, is amended to read:

96.4 Sec. 11. Minnesota Statutes 2012, section 518C.207, is amended to read:

96.5 **518C.207 ~~RECOGNITION~~ DETERMINATION OF CONTROLLING CHILD**  
 96.6 **SUPPORT ORDER.**

96.7 (a) If a proceeding is brought under this chapter and only one tribunal has issued a  
 96.8 child support order, the order of that tribunal is ~~controlling~~ controls and must be recognized.

96.9 (b) If a proceeding is brought under this chapter, and two or more child support  
 96.10 orders have been issued by tribunals of this state, another state, or a foreign country with  
 96.11 regard to the same obligor and child, a tribunal of this state having personal jurisdiction  
 96.12 over both the obligor and the individual obligee shall apply the following rules and by  
 96.13 order shall determine which order controls and must be recognized:

96.14 (1) If only one of the tribunals would have continuing, exclusive jurisdiction under  
 96.15 this chapter, the order of that tribunal is ~~controlling~~ controls.

96.16 (2) If more than one of the tribunals would have continuing, exclusive jurisdiction  
 96.17 under this chapter:

96.18 (i) an order issued by a tribunal in the current home state of the child controls; or

96.19 (ii) if an order has not been issued in the current home state of the child, the order  
 96.20 most recently issued controls.

96.21 (3) If none of the tribunals would have continuing, exclusive jurisdiction under this  
 96.22 chapter, the tribunal of this state shall issue a child support order, which controls.

96.23 (c) If two or more child support orders have been issued for the same obligor and  
 96.24 child, upon request of a party who is an individual or that is a support enforcement agency,  
 96.25 a tribunal of this state having personal jurisdiction over both the obligor and the obligee  
 96.26 who is an individual shall determine which order controls under paragraph (b). The  
 96.27 request may be filed with a registration for enforcement or registration for modification  
 96.28 pursuant to sections 518C.601 to 518C.616, or may be filed as a separate proceeding.

96.29 (d) A request to determine which is the controlling order must be accompanied  
 96.30 by a copy of every child support order in effect and the applicable record of payments.  
 96.31 The requesting party shall give notice of the request to each party whose rights may  
 96.32 be affected by the determination.

96.33 (e) The tribunal that issued the controlling order under paragraph (a), (b), or (c) has  
 96.34 continuing jurisdiction to the extent provided in section 518C.205, or 518C.206.



97.1 (f) A tribunal of this state which determines by order which is the controlling order  
 97.2 under paragraph (b), clause (1) or (2), or paragraph (c), or which issues a new controlling  
 97.3 child support order under paragraph (b), clause (3), shall state in that order:

97.4 (1) the basis upon which the tribunal made its determination;

97.5 (2) the amount of prospective support, if any; and

97.6 (3) the total amount of consolidated arrears and accrued interest, if any, under all of  
 97.7 the orders after all payments made are credited as provided by section 518C.209.

97.8 (g) Within 30 days after issuance of the order determining which is the controlling  
 97.9 order, the party obtaining that order shall file a certified copy of it with each tribunal that  
 97.10 issued or registered an earlier order of child support. A party or support enforcement  
 97.11 agency obtaining the order that fails to file a certified copy is subject to appropriate  
 97.12 sanctions by a tribunal in which the issue of failure to file arises. The failure to file does  
 97.13 not affect the validity or enforceability of the controlling order.

97.14 (h) An order that has been determined to be the controlling order, or a judgment for  
 97.15 consolidated arrears of support and interest, if any, made pursuant to this section must be  
 97.16 recognized in proceedings under this chapter.

97.17 Sec. 99. Laws 2014, chapter 189, section 16, is amended to read:

97.18 Sec. 16. Minnesota Statutes 2012, section 518C.301, is amended to read:

97.19 **518C.301 PROCEEDINGS UNDER THIS CHAPTER.**

97.20 (a) Except as otherwise provided in this chapter, sections 518C.301 to 518C.319  
 97.21 apply to all proceedings under this chapter.

97.22 ~~(b) This chapter provides for the following proceedings:~~

97.23 ~~(1) establishment of an order for spousal support or child support pursuant to~~  
 97.24 ~~section 518C.401;~~

97.25 ~~(2) enforcement of a support order and income-withholding order of another state or~~  
 97.26 ~~a foreign country without registration pursuant to sections 518C.501 and 518C.502;~~

97.27 ~~(3) registration of an order for spousal support or child support of another state or a~~  
 97.28 ~~foreign country for enforcement pursuant to sections 518C.601 to 518C.612;~~

97.29 ~~(4) modification of an order for child support or spousal support issued by a tribunal~~  
 97.30 ~~of this state pursuant to sections 518C.203 to 518C.206;~~

97.31 ~~(5) registration of an order for child support of another state or a foreign country for~~  
 97.32 ~~modification pursuant to sections 518C.601 to 518C.612;~~

97.33 ~~(6) determination of parentage of a child pursuant to section 518C.701; and~~

97.34 ~~(7) assertion of jurisdiction over nonresidents pursuant to sections 518C.201 and~~  
 97.35 ~~518C.202.~~

98.1           (e) (b) An individual petitioner or a support enforcement agency may commence  
 98.2 a proceeding authorized under this chapter by filing a petition in an initiating tribunal  
 98.3 for forwarding to a responding tribunal or by filing a petition or a comparable pleading  
 98.4 directly in a tribunal of another state or a foreign country which has or can obtain personal  
 98.5 jurisdiction over the respondent.

98.6           Sec. 100. Laws 2014, chapter 189, section 17, is amended to read:

98.7           Sec. 17. Minnesota Statutes 2012, section 518C.303, is amended to read:

98.8           **518C.303 APPLICATION OF LAW OF THIS STATE.**

98.9           Except as otherwise provided by this chapter, a responding tribunal of this state shall:

98.10          (1) apply the procedural and substantive law, ~~including the rules on choice of law,~~  
 98.11 generally applicable to similar proceedings originating in this state and may exercise all  
 98.12 powers and provide all remedies available in those proceedings; and

98.13          (2) determine the duty of support and the amount payable in accordance with the  
 98.14 law and support guidelines of this state.

98.15          Sec. 101. Laws 2014, chapter 189, section 18, is amended to read:

98.16          Sec. 18. Minnesota Statutes 2012, section 518C.304, is amended to read:

98.17          **518C.304 DUTIES OF INITIATING TRIBUNAL.**

98.18          (a) Upon the filing of a petition authorized by this chapter, an initiating tribunal of  
 98.19 this state shall forward the petition and its accompanying documents:

98.20          (1) to the responding tribunal or appropriate support enforcement agency in the  
 98.21 responding state; or

98.22          (2) if the identity of the responding tribunal is unknown, to the state information  
 98.23 agency of the responding state with a request that they be forwarded to the appropriate  
 98.24 tribunal and that receipt be acknowledged.

98.25          (b) If requested by the responding tribunal, a tribunal of this state shall issue a  
 98.26 certificate or other documents and make findings required by the law of the responding  
 98.27 state. If the responding tribunal is in a foreign country, upon request the tribunal of this  
 98.28 state shall specify the amount of support sought, convert that amount into the equivalent  
 98.29 amount in the foreign currency under applicable official or market exchange rate as  
 98.30 publicly reported, and provide other documents necessary to satisfy the requirements of  
 98.31 the responding foreign tribunal.

98.32          Sec. 102. Laws 2014, chapter 189, section 19, is amended to read:

99.1 Sec. 19. Minnesota Statutes 2012, section 518C.305, is amended to read:

99.2 **518C.305 DUTIES AND POWERS OF RESPONDING TRIBUNAL.**

99.3 (a) When a responding tribunal of this state receives a petition or comparable  
99.4 pleading from an initiating tribunal or directly pursuant to section 518C.301, paragraph (e)  
99.5 (b), it shall cause the petition or pleading to be filed and notify the petitioner where and  
99.6 when it was filed.

99.7 (b) A responding tribunal of this state, to the extent ~~otherwise authorized by~~ not  
99.8 prohibited by other law, may do one or more of the following:

99.9 (1) establish or enforce a support order, modify a child support order, determine the  
99.10 controlling child support order, or to determine parentage of a child;

99.11 (2) order an obligor to comply with a support order, specifying the amount and  
99.12 the manner of compliance;

99.13 (3) order income withholding;

99.14 (4) determine the amount of any arrearages, and specify a method of payment;

99.15 (5) enforce orders by civil or criminal contempt, or both;

99.16 (6) set aside property for satisfaction of the support order;

99.17 (7) place liens and order execution on the obligor's property;

99.18 (8) order an obligor to keep the tribunal informed of the obligor's current residential  
99.19 address, electronic mail address, telephone number, employer, address of employment,  
99.20 and telephone number at the place of employment;

99.21 (9) issue a bench warrant for an obligor who has failed after proper notice to appear  
99.22 at a hearing ordered by the tribunal and enter the bench warrant in any local and state  
99.23 computer systems for criminal warrants;

99.24 (10) order the obligor to seek appropriate employment by specified methods;

99.25 (11) award reasonable attorney's fees and other fees and costs; and

99.26 (12) grant any other available remedy.

99.27 (c) A responding tribunal of this state shall include in a support order issued under  
99.28 this chapter, or in the documents accompanying the order, the calculations on which  
99.29 the support order is based.

99.30 (d) A responding tribunal of this state may not condition the payment of a support  
99.31 order issued under this chapter upon compliance by a party with provisions for visitation.

99.32 (e) If a responding tribunal of this state issues an order under this chapter, the  
99.33 tribunal shall send a copy of the order to the petitioner and the respondent and to the  
99.34 initiating tribunal, if any.

99.35 (f) If requested to enforce a support order, arrears, or judgment or modify a support  
99.36 order stated in a foreign currency, a responding tribunal of this state shall convert the

100.1 amount stated in the foreign currency to the equivalent amount in dollars under the  
100.2 applicable official or market exchange rate as publicly reported.

100.3 Sec. 103. Laws 2014, chapter 189, section 23, is amended to read:

100.4 Sec. 23. Minnesota Statutes 2012, section 518C.310, is amended to read:

100.5 **518C.310 DUTIES OF STATE INFORMATION AGENCY.**

100.6 (a) The unit within the Department of Human Services that receives and disseminates  
100.7 incoming interstate actions under title IV-D of the Social Security Act is the State  
100.8 Information Agency under this chapter.

100.9 (b) The State Information Agency shall:

100.10 (1) compile and maintain a current list, including addresses, of the tribunals in this  
100.11 state which have jurisdiction under this chapter and any support enforcement agencies in  
100.12 this state and transmit a copy to the state information agency of every other state;

100.13 (2) maintain a register of names and addresses of tribunals and support enforcement  
100.14 agencies received from other states;

100.15 (3) forward to the appropriate tribunal in the place in this state in which the  
100.16 individual obligee or the obligor resides, or in which the obligor's property is believed  
100.17 to be located, all documents concerning a proceeding under this chapter received from  
100.18 another state or a foreign country; and

100.19 (4) obtain information concerning the location of the obligor and the obligor's  
100.20 property within this state not exempt from execution, by such means as postal verification  
100.21 and federal or state locator services, examination of telephone directories, requests for the  
100.22 obligor's address from employers, and examination of governmental records, including, to  
100.23 the extent not prohibited by other law, those relating to real property, vital statistics, law  
100.24 enforcement, taxation, motor vehicles, driver's licenses, and Social Security.

100.25 Sec. 104. Laws 2014, chapter 189, section 24, is amended to read:

100.26 Sec. 24. Minnesota Statutes 2012, section 518C.311, is amended to read:

100.27 **518C.311 PLEADINGS AND ACCOMPANYING DOCUMENTS.**

100.28 (a) A petitioner seeking to establish or modify a support order, determine parentage  
100.29 of a child, or register and modify a support order of a tribunal of another state or a foreign  
100.30 country, in a proceeding under this chapter must file a petition. Unless otherwise ordered  
100.31 under section 518C.312, the petition or accompanying documents must provide, so far  
100.32 as known, the name, residential address, and Social Security numbers of the obligor and  
100.33 the obligee or parent and alleged parent, and the name, sex, residential address, Social  
100.34 Security number, and date of birth of each child for whom support is sought or whose

101.1 ~~parenthood~~ parentage is to be determined. Unless filed at the time of registration, the  
 101.2 petition must be accompanied by a certified copy of any support order in effect known  
 101.3 to have been issued by another tribunal. The petition may include any other information  
 101.4 that may assist in locating or identifying the respondent.

101.5 (b) The petition must specify the relief sought. The petition and accompanying  
 101.6 documents must conform substantially with the requirements imposed by the forms  
 101.7 mandated by federal law for use in cases filed by a support enforcement agency.

101.8 Sec. 105. Laws 2014, chapter 189, section 27, is amended to read:

101.9 Sec. 27. Minnesota Statutes 2012, section 518C.314, is amended to read:

101.10 **518C.314 LIMITED IMMUNITY OF PETITIONER.**

101.11 (a) Participation by a petitioner in a proceeding under this chapter before a  
 101.12 responding tribunal, whether in person, by private attorney, or through services provided  
 101.13 by the support enforcement agency, does not confer personal jurisdiction over the  
 101.14 petitioner in another proceeding.

101.15 (b) A petitioner is not amenable to service of civil process while physically present  
 101.16 in this state to participate in a proceeding under this chapter.

101.17 (c) The immunity granted by this section does not extend to civil litigation based on  
 101.18 acts unrelated to a proceeding under this chapter committed by a party while physically  
 101.19 present in this state to participate in the proceeding.

101.20 Sec. 106. Laws 2014, chapter 189, section 28, is amended to read:

101.21 Sec. 28. Minnesota Statutes 2012, section 518C.316, is amended to read:

101.22 **518C.316 SPECIAL RULES OF EVIDENCE AND PROCEDURE.**

101.23 (a) The physical presence of ~~the petitioner~~ a nonresident party who is an individual  
 101.24 in a responding tribunal of this state is not required for the establishment, enforcement,  
 101.25 or modification of a support order or the rendition of a judgment determining parentage  
 101.26 of a child.

101.27 (b) ~~A verified petition,~~ An affidavit, a document substantially complying with  
 101.28 federally mandated forms, and or a document incorporated by reference in any of them,  
 101.29 not excluded under the hearsay rule if given in person, is admissible in evidence if given  
 101.30 under oath penalty of perjury by a party or witness residing outside this state.

101.31 (c) A copy of the record of child support payments certified as a true copy of the  
 101.32 original by the custodian of the record may be forwarded to a responding tribunal. The copy  
 101.33 is evidence of facts asserted in it, and is admissible to show whether payments were made.

102.1 (d) Copies of bills for testing for parentage of a child, and for prenatal and postnatal  
 102.2 health care of the mother and child, furnished to the adverse party at least ten days before  
 102.3 trial, are admissible in evidence to prove the amount of the charges billed and that the  
 102.4 charges were reasonable, necessary, and customary.

102.5 (e) Documentary evidence transmitted from outside this state to a tribunal of this state  
 102.6 by telephone, telecopier, or other electronic means that do not provide an original record  
 102.7 may not be excluded from evidence on an objection based on the means of transmission.

102.8 (f) In a proceeding under this chapter, a tribunal of this state shall permit a party  
 102.9 or witness residing outside this state to be deposed or to testify under penalty of perjury  
 102.10 by telephone, audiovisual means, or other electronic means at a designated tribunal or  
 102.11 other location. A tribunal of this state shall cooperate with other tribunals in designating  
 102.12 an appropriate location for the deposition or testimony.

102.13 (g) If a party called to testify at a civil hearing refuses to answer on the ground that  
 102.14 the testimony may be self-incriminating, the trier of fact may draw an adverse inference  
 102.15 from the refusal.

102.16 (h) A privilege against disclosure of communications between spouses does not  
 102.17 apply in a proceeding under this chapter.

102.18 (i) The defense of immunity based on the relationship of husband and wife or parent  
 102.19 and child does not apply in a proceeding under this chapter.

102.20 (j) A voluntary acknowledgment of paternity, certified as a true copy, is admissible  
 102.21 to establish parentage of a child.

102.22 Sec. 107. Laws 2014, chapter 189, section 29, is amended to read:

102.23 Sec. 29. Minnesota Statutes 2012, section 518C.317, is amended to read:

102.24 **518C.317 COMMUNICATIONS BETWEEN TRIBUNALS.**

102.25 A tribunal of this state may communicate with a tribunal outside this state in  
 102.26 ~~writing, by e-mail, or a record, or by telephone, electronic mail,~~ or other means, to obtain  
 102.27 information concerning the laws of that state, the legal effect of a judgment, decree, or  
 102.28 order of that tribunal, and the status of a proceeding. A tribunal of this state may furnish  
 102.29 similar information by similar means to a tribunal outside this state.

102.30 Sec. 108. Laws 2014, chapter 189, section 31, is amended to read:

102.31 Sec. 31. Minnesota Statutes 2012, section 518C.319, is amended to read:

102.32 **518C.319 RECEIPT AND DISBURSEMENT OF PAYMENTS.**

102.33 (a) A support enforcement agency or tribunal of this state shall disburse promptly  
 102.34 any amounts received pursuant to a support order, as directed by the order. The agency

103.1 or tribunal shall furnish to a requesting party or tribunal of another state or a foreign  
103.2 country a certified statement by the custodian of the record of the amounts and dates  
103.3 of all payments received.

103.4 (b) If neither the obligor, ~~not~~ nor the obligee who is an individual, nor the child  
103.5 resides in this state, upon request from the support enforcement agency of this state or  
103.6 another state, the support enforcement agency of this state or a tribunal of this state shall:

103.7 (1) direct that the support payment be made to the support enforcement agency in  
103.8 the state in which the obligee is receiving services; and

103.9 (2) issue and send to the obligor's employer a conforming income-withholding order  
103.10 or an administrative notice of change of payee, reflecting the redirected payments.

103.11 (c) The support enforcement agency of this state receiving redirected payments from  
103.12 another state pursuant to a law similar to paragraph (b) shall furnish to a requesting party  
103.13 or tribunal of the other state a certified statement by the custodian of the record of the  
103.14 amount and dates of all payments received.

103.15 Sec. 109. Laws 2014, chapter 189, section 43, is amended to read:

103.16 Sec. 43. Minnesota Statutes 2012, section 518C.604, is amended to read:

103.17 **518C.604 CHOICE OF LAW.**

103.18 (a) Except as otherwise provided in paragraph (d), the law of the issuing state or  
103.19 foreign country governs:

103.20 (1) the nature, extent, amount, and duration of current payments under a registered  
103.21 support order;

103.22 (2) the computation and payment of arrearages and accrual of interest on the  
103.23 arrearages under the support order; and

103.24 (3) the existence and satisfaction of other obligations under the support order.

103.25 (b) In a proceeding for arrearages under a registered support order, the statute of  
103.26 limitation under the laws of this state or of the issuing state or foreign country, whichever  
103.27 is longer, applies.

103.28 (c) A responding tribunal of this state shall apply the procedures and remedies of  
103.29 this state to enforce current support and collect arrears and interest due on a support order  
103.30 of another state or a foreign country registered in this state.

103.31 (d) After a tribunal of this state or another state determines which is the controlling  
103.32 order and issues an order consolidating arrears, if any, a tribunal of this state shall  
103.33 prospectively apply the law of the state or foreign country issuing the controlling order,  
103.34 including its law on interest on arrears, on current and future support, and on consolidated  
103.35 arrears.

104.1 Sec. 110. Laws 2014, chapter 189, section 50, is amended to read:

104.2 Sec. 50. Minnesota Statutes 2012, section 518C.611, is amended to read:

104.3 **518C.611 MODIFICATION OF CHILD SUPPORT ORDER OF ANOTHER**  
104.4 **STATE.**

104.5 (a) If section 518C.613 does not apply, upon petition a tribunal of this state may  
104.6 modify a child support order issued in another state that is registered in this state if, after  
104.7 notice and hearing, it finds that:

104.8 (1) the following requirements are met:

104.9 (i) neither the child, nor the obligee who is an individual, nor the obligor resides  
104.10 in the issuing state;

104.11 (ii) a petitioner who is a nonresident of this state seeks modification; and

104.12 (iii) the respondent is subject to the personal jurisdiction of the tribunal of this state; or

104.13 (2) this state is the residence of the child, or a party who is an individual is subject to  
104.14 the personal jurisdiction of the tribunal of this state and all of the parties who are individuals  
104.15 have filed ~~written~~ consents in a record in the issuing tribunal for a tribunal of this state to  
104.16 modify the support order and assume continuing, exclusive jurisdiction ~~over the order~~.

104.17 (b) Modification of a registered child support order is subject to the same  
104.18 requirements, procedures, and defenses that apply to the modification of an order issued  
104.19 by a tribunal of this state and the order may be enforced and satisfied in the same manner.

104.20 (c) A tribunal of this state may not modify any aspect of a child support order that  
104.21 may not be modified under the law of the issuing state, including the duration of the  
104.22 obligation of support. If two or more tribunals have issued child support orders for the  
104.23 same obligor and child, the order that controls and must be recognized under section  
104.24 518C.207 establishes the aspects of the support order which are nonmodifiable.

104.25 (d) In a proceeding to modify a child support order, the law of the state that is  
104.26 determined to have issued the initial controlling order governs the duration of the  
104.27 obligation of support. The obligor's fulfillment of the duty of support established by that  
104.28 order precludes imposition of a further obligation of support by a tribunal of this state.

104.29 (e) On issuance of an order by a tribunal of this state modifying a child support order  
104.30 issued in another state, a tribunal of this state becomes the tribunal having continuing,  
104.31 exclusive jurisdiction.

104.32 (f) Notwithstanding paragraphs (a) to ~~(d)~~ (e) and section 518C.201, paragraph (b),  
104.33 a tribunal of this state retains jurisdiction to modify an order issued by a tribunal of this  
104.34 state if:

104.35 (1) one party resides in another state; and

104.36 (2) the other party resides outside the United States.



105.1 Sec. 111. Laws 2014, chapter 189, section 51, is amended to read:

105.2 Sec. 51. Minnesota Statutes 2012, section 518C.612, is amended to read:

105.3 **518C.612 RECOGNITION OF ORDER MODIFIED IN ANOTHER STATE.**

105.4 If a child support order issued by a tribunal of this state is modified by a tribunal of  
105.5 another state which assumed jurisdiction ~~according to this chapter or a law substantially~~  
105.6 ~~similar to this chapter~~ pursuant to the Uniform Interstate Family Support Act, a tribunal of  
105.7 this state:

105.8 (1) may enforce its order that was modified only as to arrears and interest accruing  
105.9 before the modification;

105.10 (2) may provide appropriate relief for violations of its order which occurred before  
105.11 the effective date of the modification; and

105.12 (3) shall recognize the modifying order of the other state, upon registration, for the  
105.13 purpose of enforcement.

105.14 Sec. 112. Laws 2014, chapter 189, section 73, is amended to read:

105.15 Sec. 73. **EFFECTIVE DATE.**

105.16 This act ~~becomes~~ is effective on the date that the United States deposits the  
105.17 ~~instrument of ratification for the Hague Convention on the International Recovery of Child~~  
105.18 ~~Support and Other Forms of Family Maintenance with the Hague Conference on Private~~  
105.19 ~~International Law~~ July 1, 2015.

105.20 **EFFECTIVE DATE.** This section is effective July 1, 2015.

105.21 Sec. 113. **GROUP RESIDENTIAL HOUSING REPORT ON PROGRAM**  
105.22 **IMPROVEMENTS.**

105.23 (a) The commissioner shall, in coordination with stakeholders and advocates, build  
105.24 on the group residential housing (GRH) reforms made in the 2015 legislative session  
105.25 related to program integrity and uniformity, by restructuring the payment rates, exploring  
105.26 assessment tools, and proposing any other necessary modifications that will result in a  
105.27 more cost-effective program, and report to the members of the legislative committees  
105.28 having jurisdiction over GRH issues by December 15, 2015.

105.29 (b) The working group, consisting of the commissioner, stakeholders, and advocates,  
105.30 shall examine the feasibility and fiscal implications of restructuring service rates by  
105.31 eliminating the supplemental service rates, and developing a plan to fund only those  
105.32 services, based on individual need, that are not covered by medical assistance, other  
105.33 insurance, or other programs. In addition, the working group shall analyze the payment

106.1 structure, and explore different options, including tiered rates for services, and provide the  
106.2 plan and analysis under this paragraph in the report under paragraph (a).

106.3 (c) To determine individual need, the working group shall explore assessment tools,  
106.4 and determine the appropriate assessment tool for the different populations served by the  
106.5 GRH program, which include homeless individuals, individuals with mental illness, and  
106.6 individuals who are chemically dependent. The working group shall coordinate efforts  
106.7 with agency staff who have expertise related to these populations, and use relevant  
106.8 information and data that is available, to determine the most appropriate and effective  
106.9 assessment tool or tools, and provide the analysis and an assessment recommendation in  
106.10 the report under paragraph (a).

106.11 **Sec. 114. PARENTING EXPENSE ADJUSTMENT REVIEW.**

106.12 The commissioner of human services shall review the parenting expense adjustment  
106.13 in Minnesota Statutes, section 518A.36, and identify and recommend changes to the  
106.14 parenting expense adjustment. The commissioner is authorized to retain the services of  
106.15 an economist to help create an equitable parenting expense adjustment formula. The  
106.16 commissioner may hire an economist by use of a sole-source contract.

106.17 **Sec. 115. INSTRUCTIONS TO THE COMMISSIONER; CHILD**  
106.18 **MALTREATMENT SCREENING GUIDELINES.**

106.19 (a) No later than August 1, 2015, the commissioner of human services shall update the  
106.20 child maltreatment screening guidelines to require agencies to consider prior reports that  
106.21 were not screened in when determining whether a new report will or will not be screened  
106.22 in. The updated guidelines must emphasize that intervention and prevention efforts are to  
106.23 focus on child safety and the ongoing risk of child abuse or neglect, and that the health and  
106.24 safety of children are of paramount concern. The commissioner shall work with a diverse  
106.25 group of community representatives who are experts on limiting cultural and ethnic bias  
106.26 when developing the updated guidelines. The guidelines must be developed with special  
106.27 sensitivity to reducing system bias with regard to screening and assessment tools.

106.28 (b) No later than September 30, 2015, the commissioner shall publish and distribute  
106.29 the updated guidelines and ensure that all agency staff have received training on the  
106.30 updated guidelines.

106.31 (c) Agency staff must implement the guidelines by October 1, 2015.

106.32 **Sec. 116. COMMISSIONER'S DUTY TO PROVIDE TRAINING TO CHILD**  
106.33 **PROTECTION SUPERVISORS.**

107.1 The commissioner shall establish requirements for competency-based initial training,  
107.2 support, and continuing education for child protection supervisors. This would include  
107.3 developing a set of competencies specific to child protection supervisor knowledge, skills,  
107.4 and attitudes based on the Minnesota Child Welfare Practice Model. Competency-based  
107.5 training of supervisors must advance continuous emphasis and improvement in skills that  
107.6 promote the use of the client's culture as a resource and the ability to integrate the client's  
107.7 traditions, customs, values, and faith into service delivery.

107.8 Sec. 117. **CHILD PROTECTION UPDATED FORMULA.**

107.9 The commissioner of human services shall evaluate the formulas in Minnesota  
107.10 Statutes, sections 256M.41 and 256M.42, and recommend an updated equitable  
107.11 distribution formula beginning in fiscal year 2018, for funding child protection services  
107.12 and staffing to counties and tribes, taking into consideration any relief to counties and  
107.13 tribes for child welfare and foster care costs, additional tribes delivering social services,  
107.14 and any other relevant information that should be considered in developing a new  
107.15 distribution formula. The commissioner shall report to the legislative committees having  
107.16 jurisdiction over child protection issues by December 15, 2016.

107.17 Sec. 118. **TRANSFER.**

107.18 Minnesota Statutes, section 15.039, applies to the transfer from the Office of  
107.19 Ombudspersons for Families to the Department of Human Services.

107.20 Sec. 119. **REVISOR'S INSTRUCTION.**

107.21 The revisor shall alphabetize the definitions in Minnesota Statutes, section 626.556,  
107.22 subdivision 2, and correct related cross-references.

107.23 Sec. 120. **REPEALER.**

107.24 (a) Minnesota Statutes 2014, section 290.0671, subdivision 6a, is repealed.

107.25 (b) Minnesota Statutes 2014, section 257.0768, is repealed.

107.26 **EFFECTIVE DATE.** This section is effective for fiscal year 2016 and thereafter.

107.27 **ARTICLE 2**

107.28 **CHEMICAL AND MENTAL HEALTH SERVICES**

107.29 Section 1. Minnesota Statutes 2014, section 13.46, subdivision 2, is amended to read:

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

108.4 (1) according to section 13.05;

108.5 (2) according to court order;

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

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

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

108.16 (6) to administer federal funds or programs;

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

108.18 (8) to the Department of Revenue to assess parental contribution amounts for  
108.19 purposes of section 252.27, subdivision 2a, administer and evaluate tax refund or tax credit  
108.20 programs and to identify individuals who may benefit from these programs. The following  
108.21 information may be disclosed under this paragraph: an individual's and their dependent's  
108.22 names, dates of birth, Social Security numbers, income, addresses, and other data as  
108.23 required, upon request by the Department of Revenue. Disclosures by the commissioner  
108.24 of revenue to the commissioner of human services for the purposes described in this clause  
108.25 are governed by section 270B.14, subdivision 1. Tax refund or tax credit programs include,  
108.26 but are not limited to, the dependent care credit under section 290.067, the Minnesota  
108.27 working family credit under section 290.0671, the property tax refund and rental credit  
108.28 under section 290A.04, and the Minnesota education credit under section 290.0674;

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

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

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

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

109.5 (iv) to analyze public assistance employment services and program utilization,  
109.6 cost, effectiveness, and outcomes as implemented under the authority established in Title  
109.7 II, Sections 201-204 of the Ticket to Work and Work Incentives Improvement Act of  
109.8 1999. Health records governed by sections 144.291 to 144.298 and "protected health  
109.9 information" as defined in Code of Federal Regulations, title 45, section 160.103, and  
109.10 governed by Code of Federal Regulations, title 45, parts 160-164, including health care  
109.11 claims utilization information, must not be exchanged under this clause;

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

109.15 (11) data maintained by residential programs as defined in section 245A.02 may  
109.16 be disclosed to the protection and advocacy system established in this state according  
109.17 to Part C of Public Law 98-527 to protect the legal and human rights of persons with  
109.18 developmental disabilities or other related conditions who live in residential facilities for  
109.19 these persons if the protection and advocacy system receives a complaint by or on behalf  
109.20 of that person and the person does not have a legal guardian or the state or a designee of  
109.21 the state is the legal guardian of the person;

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

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

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

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

109.34 (i) the participant:

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

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

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

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

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

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

110.16 (18) the address, Social Security number, and, if available, photograph of any  
110.17 member of a household receiving food support shall be made available, on request, to a  
110.18 local, state, or federal law enforcement officer if the officer furnishes the agency with the  
110.19 name of the member and notifies the agency that:

110.20 (i) the member:

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

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

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

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

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

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

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

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

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

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

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

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

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

111.26 (27) to monitor and evaluate the Minnesota family investment program by  
111.27 exchanging data between the Departments of Human Services and Education, on  
111.28 recipients and former recipients of food support, cash assistance under chapter 256, 256D,  
111.29 256J, or 256K, child care assistance under chapter 119B, or medical programs under  
111.30 chapter 256B, 256D, or 256L;

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

112.1 (29) counties operating child care assistance programs under chapter 119B may  
 112.2 disseminate data on program participants, applicants, and providers to the commissioner  
 112.3 of education; ~~or~~

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

112.7 (31) to a health care provider governed by sections 144.291 to 144.298, to the extent  
 112.8 necessary to coordinate services, provided that a health record may be disclosed only as  
 112.9 provided under section 144.293.

112.10 (b) Information on persons who have been treated for drug or alcohol abuse may  
 112.11 only be disclosed according to the requirements of Code of Federal Regulations, title  
 112.12 42, sections 2.1 to 2.67.

112.13 (c) Data provided to law enforcement agencies under paragraph (a), clause (15),  
 112.14 (16), (17), or (18), or paragraph (b), are investigative data and are confidential or protected  
 112.15 nonpublic while the investigation is active. The data are private after the investigation  
 112.16 becomes inactive under section 13.82, subdivision 5, paragraph (a) or (b).

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

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

112.21 Sec. 2. Minnesota Statutes 2014, section 13.46, subdivision 7, is amended to read:

112.22 Subd. 7. **Mental health data.** (a) Mental health data are private data on individuals  
 112.23 and shall not be disclosed, except:

112.24 (1) pursuant to section 13.05, as determined by the responsible authority for the  
 112.25 community mental health center, mental health division, or provider;

112.26 (2) pursuant to court order;

112.27 (3) pursuant to a statute specifically authorizing access to or disclosure of mental  
 112.28 health data or as otherwise provided by this subdivision; ~~or~~

112.29 (4) to personnel of the welfare system working in the same program or providing  
 112.30 services to the same individual or family to the extent necessary to coordinate services,  
 112.31 provided that a health record may be disclosed only as provided under section 144.293;

112.32 (5) to a health care provider governed by sections 144.291 to 144.298, to the extent  
 112.33 necessary to coordinate services, provided that a health record may be disclosed only as  
 112.34 provided under section 144.293; or

112.35 (6) with the consent of the client or patient.



113.1 (b) An agency of the welfare system may not require an individual to consent to the  
113.2 release of mental health data as a condition for receiving services or for reimbursing a  
113.3 community mental health center, mental health division of a county, or provider under  
113.4 contract to deliver mental health services.

113.5 (c) Notwithstanding section 245.69, subdivision 2, paragraph (f), or any other law  
113.6 to the contrary, the responsible authority for a community mental health center, mental  
113.7 health division of a county, or a mental health provider must disclose mental health data to  
113.8 a law enforcement agency if the law enforcement agency provides the name of a client or  
113.9 patient and communicates that the:

113.10 (1) client or patient is currently involved in an emergency interaction with the law  
113.11 enforcement agency; and

113.12 (2) data is necessary to protect the health or safety of the client or patient or of  
113.13 another person.

113.14 The scope of disclosure under this paragraph is limited to the minimum necessary for  
113.15 law enforcement to respond to the emergency. Disclosure under this paragraph may include,  
113.16 but is not limited to, the name and telephone number of the psychiatrist, psychologist,  
113.17 therapist, mental health professional, practitioner, or case manager of the client or patient.  
113.18 A law enforcement agency that obtains mental health data under this paragraph shall  
113.19 maintain a record of the requestor, the provider of the information, and the client or patient  
113.20 name. Mental health data obtained by a law enforcement agency under this paragraph  
113.21 are private data on individuals and must not be used by the law enforcement agency for  
113.22 any other purpose. A law enforcement agency that obtains mental health data under this  
113.23 paragraph shall inform the subject of the data that mental health data was obtained.

113.24 (d) In the event of a request under paragraph (a), clause (4), a community mental  
113.25 health center, county mental health division, or provider must release mental health data to  
113.26 Criminal Mental Health Court personnel in advance of receiving a copy of a consent if the  
113.27 Criminal Mental Health Court personnel communicate that the:

113.28 (1) client or patient is a defendant in a criminal case pending in the district court;

113.29 (2) data being requested is limited to information that is necessary to assess whether  
113.30 the defendant is eligible for participation in the Criminal Mental Health Court; and

113.31 (3) client or patient has consented to the release of the mental health data and a copy  
113.32 of the consent will be provided to the community mental health center, county mental  
113.33 health division, or provider within 72 hours of the release of the data.

113.34 For purposes of this paragraph, "Criminal Mental Health Court" refers to a specialty  
113.35 criminal calendar of the Hennepin County District Court for defendants with mental illness  
113.36 and brain injury where a primary goal of the calendar is to assess the treatment needs of

114.1 the defendants and to incorporate those treatment needs into voluntary case disposition  
114.2 plans. The data released pursuant to this paragraph may be used for the sole purpose of  
114.3 determining whether the person is eligible for participation in mental health court. This  
114.4 paragraph does not in any way limit or otherwise extend the rights of the court to obtain the  
114.5 release of mental health data pursuant to court order or any other means allowed by law.

114.6 Sec. 3. Minnesota Statutes 2014, section 144.293, subdivision 6, is amended to read:

114.7 Subd. 6. **Consent does not expire.** Notwithstanding subdivision 4, if a patient  
114.8 explicitly gives informed consent to the release of health records for the purposes and  
114.9 restrictions in ~~clauses~~ clause (1) and, (2), or (3), the consent does not expire after one  
114.10 year for:

114.11 (1) the release of health records to a provider who is being advised or consulted with  
114.12 in connection with the releasing provider's current treatment of the patient;

114.13 (2) the release of health records to an accident and health insurer, health service plan  
114.14 corporation, health maintenance organization, or third-party administrator for purposes of  
114.15 payment of claims, fraud investigation, or quality of care review and studies, provided that:

114.16 (i) the use or release of the records complies with sections 72A.49 to 72A.505;

114.17 (ii) further use or release of the records in individually identifiable form to a person  
114.18 other than the patient without the patient's consent is prohibited; and

114.19 (iii) the recipient establishes adequate safeguards to protect the records from  
114.20 unauthorized disclosure, including a procedure for removal or destruction of information  
114.21 that identifies the patient; or

114.22 (3) the release of health records to a program in the welfare system, as defined in  
114.23 section 13.46, to the extent necessary to coordinate services for the patient.

114.24 Sec. 4. Minnesota Statutes 2014, section 245.4661, subdivision 5, is amended to read:

114.25 Subd. 5. **Planning for pilot projects.** (a) Each local plan for a pilot project, with  
114.26 the exception of the placement of a Minnesota specialty treatment facility as defined in  
114.27 paragraph (c), must be developed under the direction of the county board, or multiple  
114.28 county boards acting jointly, as the local mental health authority. The planning process  
114.29 for each pilot shall include, but not be limited to, mental health consumers, families,  
114.30 advocates, local mental health advisory councils, local and state providers, representatives  
114.31 of state and local public employee bargaining units, and the department of human services.  
114.32 As part of the planning process, the county board or boards shall designate a managing  
114.33 entity responsible for receipt of funds and management of the pilot project.

115.1 (b) For Minnesota specialty treatment facilities, the commissioner shall issue a  
115.2 request for proposal for regions in which a need has been identified for services.

115.3 (c) For purposes of this section, "Minnesota specialty treatment facility" is defined  
115.4 as an intensive ~~rehabilitative mental health~~ residential treatment service under section  
115.5 256B.0622, subdivision 2, paragraph (b).

115.6 Sec. 5. Minnesota Statutes 2014, section 245.4661, subdivision 6, is amended to read:

115.7 Subd. 6. **Duties of commissioner.** (a) For purposes of the pilot projects, the  
115.8 commissioner shall facilitate integration of funds or other resources as needed and  
115.9 requested by each project. These resources may include:

115.10 (1) community support services funds administered under Minnesota Rules, parts  
115.11 9535.1700 to 9535.1760;

115.12 (2) other mental health special project funds;

115.13 (3) medical assistance, general assistance medical care, MinnesotaCare and group  
115.14 residential housing if requested by the project's managing entity, and if the commissioner  
115.15 determines this would be consistent with the state's overall health care reform efforts; and

115.16 (4) regional treatment center resources consistent with section 246.0136, subdivision  
115.17 1; ~~and.~~

115.18 ~~(5) funds transferred from section 246.18, subdivision 8, for grants to providers to~~  
115.19 ~~participate in mental health specialty treatment services, awarded to providers through~~  
115.20 ~~a request for proposal process.~~

115.21 (b) The commissioner shall consider the following criteria in awarding start-up and  
115.22 implementation grants for the pilot projects:

115.23 (1) the ability of the proposed projects to accomplish the objectives described in  
115.24 subdivision 2;

115.25 (2) the size of the target population to be served; and

115.26 (3) geographical distribution.

115.27 (c) The commissioner shall review overall status of the projects initiatives at least  
115.28 every two years and recommend any legislative changes needed by January 15 of each  
115.29 odd-numbered year.

115.30 (d) The commissioner may waive administrative rule requirements which are  
115.31 incompatible with the implementation of the pilot project.

115.32 (e) The commissioner may exempt the participating counties from fiscal sanctions  
115.33 for noncompliance with requirements in laws and rules which are incompatible with the  
115.34 implementation of the pilot project.

116.1 (f) The commissioner may award grants to an entity designated by a county board or  
116.2 group of county boards to pay for start-up and implementation costs of the pilot project.

116.3 Sec. 6. Minnesota Statutes 2014, section 245.4661, is amended by adding a subdivision  
116.4 to read:

116.5 Subd. 9. Services and programs. (a) The following three distinct grant programs  
116.6 are funded under this section:

116.7 (1) mental health crisis services;

116.8 (2) housing with supports for adults with serious mental illness; and

116.9 (3) projects for assistance in transitioning from homelessness (PATH program).

116.10 (b) In addition, the following are eligible for grant funds:

116.11 (1) community education and prevention;

116.12 (2) client outreach;

116.13 (3) early identification and intervention;

116.14 (4) adult outpatient diagnostic assessment and psychological testing;

116.15 (5) peer support services;

116.16 (6) community support program services (CSP);

116.17 (7) adult residential crisis stabilization;

116.18 (8) supported employment;

116.19 (9) assertive community treatment (ACT);

116.20 (10) housing subsidies;

116.21 (11) basic living, social skills, and community intervention;

116.22 (12) emergency response services;

116.23 (13) adult outpatient psychotherapy;

116.24 (14) adult outpatient medication management;

116.25 (15) adult mobile crisis services;

116.26 (16) adult day treatment;

116.27 (17) partial hospitalization;

116.28 (18) adult residential treatment;

116.29 (19) adult mental health targeted case management;

116.30 (20) intensive community residential services (IRCS); and

116.31 (21) transportation.

116.32 Sec. 7. Minnesota Statutes 2014, section 245.4661, is amended by adding a subdivision  
116.33 to read:

117.1 Subd. 10. Commissioner duty to report on use of grant funds biennially. By  
117.2 November 1, 2016, and biennially thereafter, the commissioner of human services shall  
117.3 provide sufficient information to the members of the legislative committees having  
117.4 jurisdiction over mental health funding and policy issues to evaluate the use of funds  
117.5 appropriated under this section of law. The commissioner shall provide, at a minimum,  
117.6 the following information:

117.7 (1) the amount of funding to mental health initiatives, what programs and services  
117.8 were funded in the previous two years, gaps in services that each initiative brought to  
117.9 the attention of the commissioner, and outcome data for the programs and services that  
117.10 were funded; and

117.11 (2) the amount of funding for other targeted services and the location of services.

117.12 Sec. 8. Minnesota Statutes 2014, section 245.467, subdivision 6, is amended to read:

117.13 Subd. 6. Restricted access to data. The county board shall establish procedures  
117.14 to ensure that the names and addresses of persons receiving mental health services are  
117.15 disclosed only to:

117.16 (1) county employees who are specifically responsible for determining county of  
117.17 financial responsibility or making payments to providers; ~~and~~

117.18 (2) staff who provide treatment services or case management and their clinical  
117.19 supervisors; and

117.20 (3) personnel of the welfare system or health care providers who have access to the  
117.21 data under section 13.46, subdivision 7.

117.22 Release of mental health data on individuals submitted under subdivisions 4 and 5,  
117.23 to persons other than those specified in this subdivision, or use of this data for purposes  
117.24 other than those stated in subdivisions 4 and 5, results in civil or criminal liability under  
117.25 the standards in section 13.08 or 13.09.

117.26 Sec. 9. Minnesota Statutes 2014, section 245.469, is amended by adding a subdivision  
117.27 to read:

117.28 Subd. 3. Commissioner duties. By July 1, 2016, unless otherwise specified, the  
117.29 commissioner shall:

117.30 (1) enhance oversight and training of the state's mobile crisis services to ensure  
117.31 consistency throughout the state, including the development and implementation of a  
117.32 certification process for mental health emergency telephone lines;

117.33 (2) develop standards for crisis services to ensure uniformity in the services that  
117.34 crisis response providers are delivering to clients;

118.1 (3) provide specialty telephone consultation 24 hours per day to mobile crisis  
 118.2 teams serving persons with traumatic brain injury or an intellectual disability who are  
 118.3 experiencing a mental health crisis;

118.4 (4) establish a single statewide mental health crisis phone number to immediately  
 118.5 connect the person in crisis with the closest crisis response provider; and

118.6 (5) by July 1, 2018, provide 24/7 availability of mobile crisis teams throughout  
 118.7 the state.

118.8 Sec. 10. Minnesota Statutes 2014, section 245.4876, subdivision 7, is amended to read:

118.9 Subd. 7. **Restricted access to data.** The county board shall establish procedures  
 118.10 to ensure that the names and addresses of children receiving mental health services and  
 118.11 their families are disclosed only to:

118.12 (1) county employees who are specifically responsible for determining county of  
 118.13 financial responsibility or making payments to providers; ~~and~~

118.14 (2) staff who provide treatment services or case management and their clinical  
 118.15 supervisors; and

118.16 (3) personnel of the welfare system or health care providers who have access to the  
 118.17 data under section 13.46, subdivision 7.

118.18 Release of mental health data on individuals submitted under subdivisions 5 and 6,  
 118.19 to persons other than those specified in this subdivision, or use of this data for purposes  
 118.20 other than those stated in subdivisions 5 and 6, results in civil or criminal liability under  
 118.21 section 13.08 or 13.09.

118.22 Sec. 11. Minnesota Statutes 2014, section 245.4889, subdivision 1, is amended to read:

118.23 Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized  
 118.24 to make grants from available appropriations to assist:

118.25 (1) counties;

118.26 (2) Indian tribes;

118.27 (3) children's collaboratives under section 124D.23 or 245.493; or

118.28 (4) mental health service providers

118.29 ~~for providing services to children with emotional disturbances as defined in section~~  
 118.30 ~~245.4871, subdivision 15, and their families. The commissioner may also authorize~~  
 118.31 ~~grants to young adults meeting the criteria for transition services in section 245.4875,~~  
 118.32 ~~subdivision 8, and their families.~~

118.33 (b) The following services are eligible for grants under this section:

- 119.1 (1) services to children with emotional disturbances as defined in section 245.4871,  
 119.2 subdivision 15, and their families;
- 119.3 (2) transition services under section 245.4875, subdivision 8, for young adults under  
 119.4 age 21 and their families;
- 119.5 (3) respite care services for children with severe emotional disturbances who are at  
 119.6 risk of out-of-home placement;
- 119.7 (4) children's mental health crisis services;
- 119.8 (5) mental health services for people from cultural and ethnic minorities;
- 119.9 (6) children's mental health screening and follow-up diagnostic assessment and  
 119.10 treatment;
- 119.11 (7) services to promote and develop the capacity of providers to use evidence-based  
 119.12 practices in providing children's mental health services;
- 119.13 (8) school-linked mental health services;
- 119.14 (9) building evidence-based mental health intervention capacity for children birth to  
 119.15 age five;
- 119.16 (10) suicide prevention and counseling services that use text messaging statewide;
- 119.17 (11) mental health first aid training;
- 119.18 (12) training for parents, collaborative partners, and mental health providers on the  
 119.19 impact of adverse childhood experiences and trauma and development of an interactive  
 119.20 Web site to share information and strategies to promote resilience and prevent trauma;
- 119.21 (13) transition age services to develop or expand mental health treatment and  
 119.22 supports for adolescents and young adults 26 years of age or younger;
- 119.23 (14) early childhood mental health consultation;
- 119.24 (15) evidence-based interventions for youth at risk of developing or experiencing a  
 119.25 first episode of psychosis, and a public awareness campaign on the signs and symptoms of  
 119.26 psychosis; and
- 119.27 (16) psychiatric consultation for primary care practitioners.
- 119.28 (c) Services under paragraph (a) (b) must be designed to help each child to function  
 119.29 and remain with the child's family in the community and delivered consistent with the  
 119.30 child's treatment plan. Transition services to eligible young adults under paragraph (a) (b)  
 119.31 must be designed to foster independent living in the community.

119.32 Sec. 12. Minnesota Statutes 2014, section 245.4889, is amended by adding a  
 119.33 subdivision to read:

119.34 Subd. 3. **Commissioner duty to report on use of grant funds biennially.** By  
 119.35 November 1, 2016, and biennially thereafter, the commissioner of human services shall

120.1 provide sufficient information to the members of the legislative committees having  
 120.2 jurisdiction over mental health funding and policy issues to evaluate the use of funds  
 120.3 appropriated under this section. The commissioner shall provide, at a minimum, the  
 120.4 following information:

120.5 (1) the amount of funding for children's mental health grants, what programs and  
 120.6 services were funded in the previous two years, and outcome data for the programs and  
 120.7 services that were funded; and

120.8 (2) the amount of funding for other targeted services and the location of services.

120.9 Sec. 13. **[245.735] EXCELLENCE IN MENTAL HEALTH DEMONSTRATION**  
 120.10 **PROJECT.**

120.11 Subdivision 1. **Excellence in Mental Health demonstration project.** The  
 120.12 commissioner shall develop and execute projects to reform the mental health system by  
 120.13 participating in the Excellence in Mental Health demonstration project.

120.14 Subd. 2. **Federal proposal.** The commissioner shall develop and submit to the  
 120.15 United States Department of Health and Human Services a proposal for the Excellence  
 120.16 in Mental Health demonstration project. The proposal shall include any necessary state  
 120.17 plan amendments, waivers, requests for new funding, realignment of existing funding, and  
 120.18 other authority necessary to implement the projects specified in subdivision 4.

120.19 Subd. 3. **Rules.** By January 15, 2017, the commissioner shall adopt rules that meet  
 120.20 the criteria in subdivision 4, paragraph (a), to establish standards for state certification  
 120.21 of community behavioral health clinics, and rules that meet the criteria in subdivision 4,  
 120.22 paragraph (b), to implement a prospective payment system for medical assistance payment  
 120.23 of mental health services delivered in certified community behavioral health clinics. These  
 120.24 rules shall comply with federal requirements for certification of community behavioral  
 120.25 health clinics and the prospective payment system and shall apply to community mental  
 120.26 health centers, mental health clinics, mental health residential treatment centers, essential  
 120.27 community providers, federally qualified health centers, and rural health clinics. The  
 120.28 commissioner may adopt rules under this subdivision using the expedited process in  
 120.29 section 14.389.

120.30 Subd. 4. **Reform projects.** (a) The commissioner shall establish standards for state  
 120.31 certification of clinics as certified community behavioral health clinics, in accordance with  
 120.32 the criteria published on or before September 1, 2015, by the United States Department  
 120.33 of Health and Human Services. Certification standards established by the commissioner  
 120.34 shall require that:



121.1 (1) clinic staff have backgrounds in diverse disciplines, include licensed mental  
121.2 health professionals, and are culturally and linguistically trained to serve the needs of the  
121.3 clinic's patient population;

121.4 (2) clinic services are available and accessible and that crisis management services  
121.5 are available 24 hours per day;

121.6 (3) fees for clinic services are established using a sliding fee scale and services to  
121.7 patients are not denied or limited due to a patient's inability to pay for services;

121.8 (4) clinics provide coordination of care across settings and providers to ensure  
121.9 seamless transitions for patients across the full spectrum of health services, including  
121.10 acute, chronic, and behavioral needs. Care coordination may be accomplished through  
121.11 partnerships or formal contracts with federally qualified health centers, inpatient  
121.12 psychiatric facilities, substance use and detoxification facilities, community-based mental  
121.13 health providers, and other community services, supports, and providers including  
121.14 schools, child welfare agencies, juvenile and criminal justice agencies, Indian Health  
121.15 Services clinics, tribally licensed health care and mental health facilities, urban Indian  
121.16 health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in  
121.17 centers, acute care hospitals, and hospital outpatient clinics;

121.18 (5) services provided by clinics include crisis mental health services, emergency  
121.19 crisis intervention services, and stabilization services; screening, assessment, and diagnosis  
121.20 services, including risk assessments and level of care determinations; patient-centered  
121.21 treatment planning; outpatient mental health and substance use services; targeted case  
121.22 management; psychiatric rehabilitation services; peer support and counselor services and  
121.23 family support services; and intensive community-based mental health services, including  
121.24 mental health services for members of the armed forces and veterans; and

121.25 (6) clinics comply with quality assurance reporting requirements and other reporting  
121.26 requirements, including any required reporting of encounter data, clinical outcomes data,  
121.27 and quality data.

121.28 (b) The commissioner shall establish standards and methodologies for a prospective  
121.29 payment system for medical assistance payments for mental health services delivered by  
121.30 certified community behavioral health clinics, in accordance with guidance issued on or  
121.31 before September 1, 2015, by the Centers for Medicare and Medicaid Services. During the  
121.32 operation of the demonstration project, payments shall comply with federal requirements  
121.33 for a 90 percent enhanced federal medical assistance percentage.

121.34 Subd. 5. **Public participation.** In developing the projects under subdivision 4, the  
121.35 commissioner shall consult with mental health providers, advocacy organizations, licensed

122.1 mental health professionals, and Minnesota public health care program enrollees who  
 122.2 receive mental health services and their families.

122.3 Subd. 6. **Information systems support.** The commissioner and the state chief  
 122.4 information officer shall provide information systems support to the projects as necessary  
 122.5 to comply with federal requirements and the deadlines in subdivision 3.

122.6 Sec. 14. Minnesota Statutes 2014, section 246.18, subdivision 8, is amended to read:

122.7 Subd. 8. **State-operated services account.** (a) The state-operated services account is  
 122.8 established in the special revenue fund. Revenue generated by new state-operated services  
 122.9 listed under this section established after July 1, 2010, that are not enterprise activities must  
 122.10 be deposited into the state-operated services account, unless otherwise specified in law:

- 122.11 (1) intensive residential treatment services;
- 122.12 (2) foster care services; and
- 122.13 (3) psychiatric extensive recovery treatment services.

122.14 (b) Funds deposited in the state-operated services account are ~~available~~ appropriated  
 122.15 to the commissioner of human services for the purposes of:

- 122.16 (1) providing services needed to transition individuals from institutional settings  
 122.17 within state-operated services to the community when those services have no other  
 122.18 adequate funding source; and

122.19 (2) ~~grants to providers participating in mental health specialty treatment services~~  
 122.20 ~~under section 245.4661; and~~

122.21 (3) ~~to fund the operation of the intensive residential treatment service program in~~  
 122.22 ~~Willmar.~~

122.23 Sec. 15. Minnesota Statutes 2014, section 253B.18, subdivision 4c, is amended to read:

122.24 Subd. 4c. **Special review board.** (a) The commissioner shall establish one or more  
 122.25 panels of a special review board. The board shall consist of three members experienced  
 122.26 in the field of mental illness. One member of each special review board panel shall be a  
 122.27 psychiatrist or a doctoral level psychologist with forensic experience and one member  
 122.28 shall be an attorney. No member shall be affiliated with the Department of Human  
 122.29 Services. The special review board shall meet at least every six months and at the call of  
 122.30 the commissioner. It shall hear and consider all petitions for a reduction in custody or to  
 122.31 appeal a revocation of provisional discharge. A "reduction in custody" means transfer  
 122.32 from a secure treatment facility, discharge, and provisional discharge. Patients may be  
 122.33 transferred by the commissioner between secure treatment facilities without a special  
 122.34 review board hearing.

123.1 Members of the special review board shall receive compensation and reimbursement  
123.2 for expenses as established by the commissioner.

123.3 (b) The special review board must review each denied petition under subdivision  
123.4 5 for barriers and obstacles preventing the patient from progressing in treatment. Based  
123.5 on the cases before the board in the previous year, the special review board shall provide  
123.6 to the commissioner an annual summation of the barriers to treatment progress, and  
123.7 recommendations to achieve the common goal of making progress in treatment.

123.8 (c) A petition filed by a person committed as mentally ill and dangerous to the  
123.9 public under this section must be heard as provided in subdivision 5 and, as applicable,  
123.10 subdivision 13. A petition filed by a person committed as a sexual psychopathic personality  
123.11 or as a sexually dangerous person under chapter 253D, or committed as both mentally ill  
123.12 and dangerous to the public under this section and as a sexual psychopathic personality or  
123.13 as a sexually dangerous person must be heard as provided in section 253D.27.

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

123.15 Sec. 16. Minnesota Statutes 2014, section 253B.18, subdivision 5, is amended to read:

123.16 Subd. 5. **Petition; notice of hearing; attendance; order.** (a) A petition for  
123.17 a reduction in custody or revocation of provisional discharge shall be filed with the  
123.18 commissioner and may be filed by the patient or by the head of the treatment facility. A  
123.19 patient may not petition the special review board for six months following commitment  
123.20 under subdivision 3 or following the final disposition of any previous petition and  
123.21 subsequent appeal by the patient. The head of the treatment facility must schedule a  
123.22 hearing before the special review board for any patient who has not appeared before the  
123.23 special review board in the previous three years, and schedule a hearing at least every  
123.24 three years thereafter. The medical director may petition at any time.

123.25 (b) Fourteen days prior to the hearing, the committing court, the county attorney of  
123.26 the county of commitment, the designated agency, interested person, the petitioner, and  
123.27 the petitioner's counsel shall be given written notice by the commissioner of the time and  
123.28 place of the hearing before the special review board. Only those entitled to statutory notice  
123.29 of the hearing or those administratively required to attend may be present at the hearing.  
123.30 The patient may designate interested persons to receive notice by providing the names  
123.31 and addresses to the commissioner at least 21 days before the hearing. The board shall  
123.32 provide the commissioner with written findings of fact and recommendations within 21  
123.33 days of the hearing. The commissioner shall issue an order no later than 14 days after  
123.34 receiving the recommendation of the special review board. A copy of the order shall be  
123.35 mailed to every person entitled to statutory notice of the hearing within five days after it

124.1 is signed. No order by the commissioner shall be effective sooner than 30 days after the  
 124.2 order is signed, unless the county attorney, the patient, and the commissioner agree that  
 124.3 it may become effective sooner.

124.4 (c) The special review board shall hold a hearing on each petition prior to making  
 124.5 its recommendation to the commissioner. The special review board proceedings are not  
 124.6 contested cases as defined in chapter 14. Any person or agency receiving notice that  
 124.7 submits documentary evidence to the special review board prior to the hearing shall also  
 124.8 provide copies to the patient, the patient's counsel, the county attorney of the county of  
 124.9 commitment, the case manager, and the commissioner.

124.10 (d) Prior to the final decision by the commissioner, the special review board may be  
 124.11 reconvened to consider events or circumstances that occurred subsequent to the hearing.

124.12 (e) In making their recommendations and order, the special review board and  
 124.13 commissioner must consider any statements received from victims under subdivision 5a.

124.14 **EFFECTIVE DATE.** This section is effective January 1, 2016, with hearings  
 124.15 starting no later than February 1, 2016.

124.16 Sec. 17. Minnesota Statutes 2014, section 254B.05, subdivision 5, is amended to read:

124.17 Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for  
 124.18 chemical dependency services and service enhancements funded under this chapter.

124.19 (b) Eligible chemical dependency treatment services include:

124.20 (1) outpatient treatment services that are licensed according to Minnesota Rules,  
 124.21 parts 9530.6405 to 9530.6480, or applicable tribal license;

124.22 (2) medication-assisted therapy services that are licensed according to Minnesota  
 124.23 Rules, parts 9530.6405 to 9530.6480 and 9530.6500, or applicable tribal license;

124.24 (3) medication-assisted therapy plus enhanced treatment services that meet the  
 124.25 requirements of clause (2) and provide nine hours of clinical services each week;

124.26 (4) high, medium, and low intensity residential treatment services that are licensed  
 124.27 according to Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505, or applicable  
 124.28 tribal license which provide, respectively, 30, 15, and five hours of clinical services each  
 124.29 week;

124.30 (5) hospital-based treatment services that are licensed according to Minnesota Rules,  
 124.31 parts 9530.6405 to 9530.6480, or applicable tribal license and licensed as a hospital under  
 124.32 sections 144.50 to 144.56;

124.33 (6) adolescent treatment programs that are licensed as outpatient treatment programs  
 124.34 according to Minnesota Rules, parts 9530.6405 to 9530.6485, or as residential treatment

125.1 programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to  
125.2 2960.0490, or applicable tribal license; ~~and~~

125.3 (7) high-intensity residential treatment services that are licensed according to  
125.4 Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505, or applicable tribal  
125.5 license, which provide 30 hours of clinical services each week provided by a state-operated  
125.6 vendor or to clients who have been civilly committed to the commissioner, present the  
125.7 most complex and difficult care needs, and are a potential threat to the community; and

125.8 (8) room and board facilities that meet the requirements of section 254B.05,  
125.9 subdivision 1a.

125.10 (c) The commissioner shall establish higher rates for programs that meet the  
125.11 requirements of paragraph (b) and the following additional requirements:

125.12 (1) programs that serve parents with their children if the program:

125.13 (i) provides on-site child care during hours of treatment activity that meets the  
125.14 requirements in Minnesota Rules, part 9530.6490, or section 245A.03, subdivision 2; or

125.15 (ii) arranges for off-site child care during hours of treatment activity at a facility that  
125.16 is licensed under chapter 245A as:

125.17 (A) a child care center under Minnesota Rules, chapter 9503; or

125.18 (B) a family child care home under Minnesota Rules, chapter 9502;

125.19 (2) culturally specific programs as defined in section 254B.01, subdivision 8, if the  
125.20 program meets the requirements in Minnesota Rules, part 9530.6605, subpart 13;

125.21 (3) programs that offer medical services delivered by appropriately credentialed  
125.22 health care staff in an amount equal to two hours per client per week if the medical  
125.23 needs of the client and the nature and provision of any medical services provided are  
125.24 documented in the client file; and

125.25 (4) programs that offer services to individuals with co-occurring mental health and  
125.26 chemical dependency problems if:

125.27 (i) the program meets the co-occurring requirements in Minnesota Rules, part  
125.28 9530.6495;

125.29 (ii) 25 percent of the counseling staff are licensed mental health professionals, as  
125.30 defined in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing  
125.31 candidates under the supervision of a licensed alcohol and drug counselor supervisor and  
125.32 licensed mental health professional, except that no more than 50 percent of the mental  
125.33 health staff may be students or licensing candidates with time documented to be directly  
125.34 related to provisions of co-occurring services;

125.35 (iii) clients scoring positive on a standardized mental health screen receive a mental  
125.36 health diagnostic assessment within ten days of admission;

126.1 (iv) the program has standards for multidisciplinary case review that include a  
126.2 monthly review for each client that, at a minimum, includes a licensed mental health  
126.3 professional and licensed alcohol and drug counselor, and their involvement in the review  
126.4 is documented;

126.5 (v) family education is offered that addresses mental health and substance abuse  
126.6 disorders and the interaction between the two; and

126.7 (vi) co-occurring counseling staff will receive eight hours of co-occurring disorder  
126.8 training annually.

126.9 (d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program  
126.10 that provides arrangements for off-site child care must maintain current documentation at  
126.11 the chemical dependency facility of the child care provider's current licensure to provide  
126.12 child care services. Programs that provide child care according to paragraph (c), clause  
126.13 (1), must be deemed in compliance with the licensing requirements in Minnesota Rules,  
126.14 part 9530.6490.

126.15 (e) Adolescent residential programs that meet the requirements of Minnesota  
126.16 Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the  
126.17 requirements in paragraph (c), clause (4), items (i) to (iv).

126.18 Sec. 18. Minnesota Statutes 2014, section 254B.12, subdivision 2, is amended to read:

126.19 Subd. 2. **Payment methodology for highly specialized vendors.** (a)

126.20 Notwithstanding subdivision 1, the commissioner shall seek federal authority to develop  
126.21 separate payment methodologies for chemical dependency treatment services provided  
126.22 under the consolidated chemical dependency treatment fund: (1) by a state-operated  
126.23 vendor; or (2) for persons who have been civilly committed to the commissioner, present  
126.24 the most complex and difficult care needs, and are a potential threat to the community. A  
126.25 payment methodology under this subdivision is effective for services provided on or after  
126.26 October 1, 2015, or on or after the receipt of federal approval, whichever is later.

126.27 ~~(b) Before implementing an approved payment methodology under paragraph~~  
126.28 ~~(a), the commissioner must also receive any necessary legislative approval of required~~  
126.29 ~~changes to state law or funding.~~

126.30 Sec. 19. Minnesota Statutes 2014, section 256B.0615, subdivision 3, is amended to read:

126.31 Subd. 3. **Eligibility.** Peer support services may be made available to consumers  
126.32 of (1) intensive ~~rehabilitative mental health~~ residential treatment services under section  
126.33 256B.0622; (2) adult rehabilitative mental health services under section 256B.0623; and

127.1 (3) crisis stabilization and mental health mobile crisis intervention services under section  
127.2 256B.0624.

127.3 Sec. 20. Minnesota Statutes 2014, section 256B.0622, subdivision 1, is amended to read:

127.4 Subdivision 1. **Scope.** Subject to federal approval, medical assistance covers  
127.5 medically necessary, ~~intensive nonresidential~~ assertive community treatment and intensive  
127.6 residential rehabilitative mental health treatment services as defined in subdivision 2, for  
127.7 recipients as defined in subdivision 3, when the services are provided by an entity meeting  
127.8 the standards in this section.

127.9 Sec. 21. Minnesota Statutes 2014, section 256B.0622, subdivision 2, is amended to read:

127.10 Subd. 2. **Definitions.** For purposes of this section, the following terms have the  
127.11 meanings given them.

127.12 (a) ~~"Intensive nonresidential rehabilitative mental health services" means adult~~  
127.13 ~~rehabilitative mental health services as defined in section 256B.0623, subdivision 2,~~  
127.14 ~~paragraph (a), except that these services are provided by a multidisciplinary staff using~~  
127.15 ~~a total team approach consistent with assertive community treatment, the Fairweather~~  
127.16 ~~Lodge treatment model, as defined by the standards established by the National Coalition~~  
127.17 ~~for Community Living, and other evidence-based practices, and directed to recipients with~~  
127.18 ~~a serious mental illness who require intensive services. "Assertive community treatment"~~  
127.19 means intensive nonresidential rehabilitative mental health services provided according  
127.20 to the evidence-based practice of assertive community treatment. Core elements of this  
127.21 service include, but are not limited to:

127.22 (1) a multidisciplinary staff who utilize a total team approach and who serve as a  
127.23 fixed point of responsibility for all service delivery;

127.24 (2) providing services 24 hours per day and 7 days per week;

127.25 (3) providing the majority of services in a community setting;

127.26 (4) offering a low ratio of recipients to staff; and

127.27 (5) providing service that is not time-limited.

127.28 (b) "Intensive residential ~~rehabilitative mental health~~ treatment services" means  
127.29 short-term, time-limited services provided in a residential setting to recipients who are  
127.30 in need of more restrictive settings and are at risk of significant functional deterioration  
127.31 if they do not receive these services. Services are designed to develop and enhance  
127.32 psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live  
127.33 in a more independent setting. Services must be directed toward a targeted discharge

128.1 date with specified client outcomes ~~and must be consistent with the Fairweather Lodge~~  
 128.2 ~~treatment model as defined in paragraph (a), and other evidence-based practices.~~

128.3 (c) "Evidence-based practices" are nationally recognized mental health services that  
 128.4 are proven by substantial research to be effective in helping individuals with serious  
 128.5 mental illness obtain specific treatment goals.

128.6 (d) "Overnight staff" means a member of the intensive residential rehabilitative  
 128.7 mental health treatment team who is responsible during hours when recipients are  
 128.8 typically asleep.

128.9 (e) "Treatment team" means all staff who provide services under this section to  
 128.10 recipients. At a minimum, this includes the clinical supervisor, mental health professionals  
 128.11 as defined in section 245.462, subdivision 18, clauses (1) to (6); mental health practitioners  
 128.12 as defined in section 245.462, subdivision 17; mental health rehabilitation workers under  
 128.13 section 256B.0623, subdivision 5, clause (3); and certified peer specialists under section  
 128.14 256B.0615.

128.15 Sec. 22. Minnesota Statutes 2014, section 256B.0622, subdivision 3, is amended to read:

128.16 Subd. 3. **Eligibility.** An eligible recipient is an individual who:

128.17 (1) is age 18 or older;

128.18 (2) is eligible for medical assistance;

128.19 (3) is diagnosed with a mental illness;

128.20 (4) because of a mental illness, has substantial disability and functional impairment  
 128.21 in three or more of the areas listed in section 245.462, subdivision 11a, so that  
 128.22 self-sufficiency is markedly reduced;

128.23 (5) has one or more of the following: a history of ~~two or more~~ recurring or prolonged  
 128.24 inpatient hospitalizations in the past year, significant independent living instability,  
 128.25 homelessness, or very frequent use of mental health and related services yielding poor  
 128.26 outcomes; and

128.27 (6) in the written opinion of a licensed mental health professional, has the need for  
 128.28 mental health services that cannot be met with other available community-based services,  
 128.29 or is likely to experience a mental health crisis or require a more restrictive setting if  
 128.30 intensive rehabilitative mental health services are not provided.

128.31 Sec. 23. Minnesota Statutes 2014, section 256B.0622, subdivision 4, is amended to read:

128.32 Subd. 4. **Provider certification and contract requirements.** (a) The ~~intensive~~  
 128.33 ~~nonresidential rehabilitative mental health services~~ assertive community treatment  
 128.34 provider must:



129.1 (1) have a contract with the host county to provide intensive adult rehabilitative  
129.2 mental health services; and

129.3 (2) be certified by the commissioner as being in compliance with this section and  
129.4 section 256B.0623.

129.5 (b) The intensive residential ~~rehabilitative-mental health~~ treatment services provider  
129.6 must:

129.7 (1) be licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;

129.8 (2) not exceed 16 beds per site;

129.9 (3) comply with the additional standards in this section; and

129.10 (4) have a contract with the host county to provide these services.

129.11 (c) The commissioner shall develop procedures for counties and providers to submit  
129.12 contracts and other documentation as needed to allow the commissioner to determine  
129.13 whether the standards in this section are met.

129.14 Sec. 24. Minnesota Statutes 2014, section 256B.0622, subdivision 5, is amended to read:

129.15 Subd. 5. **Standards applicable to both nonresidential assertive community**  
129.16 **treatment and residential providers.** (a) Services must be provided by qualified staff as  
129.17 defined in section 256B.0623, subdivision 5, who are trained and supervised according to  
129.18 section 256B.0623, subdivision 6, except that mental health rehabilitation workers acting  
129.19 as overnight staff are not required to comply with section 256B.0623, subdivision 5,  
129.20 clause ~~(3)~~ (4), item (iv).

129.21 (b) The clinical supervisor must be an active member of the treatment team. The  
129.22 treatment team must meet with the clinical supervisor at least weekly to discuss recipients'  
129.23 progress and make rapid adjustments to meet recipients' needs. The team meeting shall  
129.24 include recipient-specific case reviews and general treatment discussions among team  
129.25 members. Recipient-specific case reviews and planning must be documented in the  
129.26 individual recipient's treatment record.

129.27 (c) Treatment staff must have prompt access in person or by telephone to a mental  
129.28 health practitioner or mental health professional. The provider must have the capacity to  
129.29 promptly and appropriately respond to emergent needs and make any necessary staffing  
129.30 adjustments to assure the health and safety of recipients.

129.31 (d) The initial functional assessment must be completed within ten days of intake  
129.32 and updated at least every ~~three months~~ 30 days for intensive residential treatment services  
129.33 and every six months for assertive community treatment, or prior to discharge from the  
129.34 service, whichever comes first.

130.1 (e) The initial individual treatment plan must be completed within ten days of intake  
 130.2 ~~and for assertive community treatment and within 24 hours of admission for intensive~~  
 130.3 residential treatment services. Within ten days of admission, the initial treatment plan  
 130.4 must be refined and further developed for intensive residential treatment services, except  
 130.5 for providers certified according to Minnesota Rules, parts 9533.0010 to 9533.0180.  
 130.6 The individual treatment plan must be reviewed with the recipient and updated at least  
 130.7 monthly with the recipient for intensive residential treatment services and at least every  
 130.8 six months for assertive community treatment.

130.9 Sec. 25. Minnesota Statutes 2014, section 256B.0622, subdivision 7, is amended to read:

130.10 Subd. 7. **Additional standards for ~~nonresidential services~~ assertive community**  
 130.11 **treatment**. The standards in this subdivision apply to ~~intensive nonresidential~~  
 130.12 ~~rehabilitative mental health~~ assertive community treatment services.

130.13 (1) The treatment team must use team treatment, not an individual treatment model.

130.14 (2) The clinical supervisor must function as a practicing clinician at least on a  
 130.15 part-time basis.

130.16 (3) The staffing ratio must not exceed ten recipients to one full-time equivalent  
 130.17 treatment team position.

130.18 (4) Services must be available at times that meet client needs.

130.19 (5) The treatment team must actively and assertively engage and reach out to the  
 130.20 recipient's family members and significant others, after obtaining the recipient's permission.

130.21 (6) The treatment team must establish ongoing communication and collaboration  
 130.22 between the team, family, and significant others and educate the family and significant  
 130.23 others about mental illness, symptom management, and the family's role in treatment.

130.24 (7) The treatment team must provide interventions to promote positive interpersonal  
 130.25 relationships.

130.26 Sec. 26. Minnesota Statutes 2014, section 256B.0622, subdivision 8, is amended to read:

130.27 Subd. 8. **Medical assistance payment for intensive rehabilitative mental health**  
 130.28 **services.** (a) Payment for intensive residential and nonresidential treatment services  
 130.29 and assertive community treatment in this section shall be based on one daily rate per  
 130.30 provider inclusive of the following services received by an eligible recipient in a given  
 130.31 calendar day: all rehabilitative services under this section, staff travel time to provide  
 130.32 rehabilitative services under this section, and nonresidential crisis stabilization services  
 130.33 under section 256B.0624.

131.1 (b) Except as indicated in paragraph (c), payment will not be made to more than one  
 131.2 entity for each recipient for services provided under this section on a given day. If services  
 131.3 under this section are provided by a team that includes staff from more than one entity, the  
 131.4 team must determine how to distribute the payment among the members.

131.5 (c) The commissioner shall determine one rate for each provider that will bill  
 131.6 medical assistance for residential services under this section and one rate for each  
 131.7 ~~nonresidential~~ assertive community treatment provider. If a single entity provides both  
 131.8 services, one rate is established for the entity's residential services and another rate for the  
 131.9 entity's nonresidential services under this section. A provider is not eligible for payment  
 131.10 under this section without authorization from the commissioner. The commissioner shall  
 131.11 develop rates using the following criteria:

131.12 ~~(1) the cost for similar services in the local trade area;~~

131.13 ~~(2)~~ (1) the provider's cost for services shall include direct services costs, other  
 131.14 program costs, and other costs determined as follows:

131.15 (i) the direct services costs must be determined using actual costs of salaries, benefits,  
 131.16 payroll taxes, and training of direct service staff and service-related transportation;

131.17 (ii) other program costs not included in item (i) must be determined as a specified  
 131.18 percentage of the direct services costs as determined by item (i). The percentage used shall  
 131.19 be determined by the commissioner based upon the average of percentages that represent  
 131.20 the relationship of other program costs to direct services costs among the entities that  
 131.21 provide similar services;

131.22 ~~(iii) in situations where a provider of intensive residential services can demonstrate~~  
 131.23 ~~actual program-related physical plant costs in excess of the group residential housing~~  
 131.24 ~~reimbursement, the commissioner may include these costs in the program rate, so long~~  
 131.25 ~~as the additional reimbursement does not subsidize the room and board expenses of the~~  
 131.26 ~~program~~ physical plant costs calculated based on the percentage of space within the  
 131.27 program that is entirely devoted to treatment and programming. This does not include  
 131.28 administrative or residential space;

131.29 (iv) ~~intensive nonresidential services~~ assertive community treatment physical plant  
 131.30 costs must be reimbursed as part of the costs described in item (ii); and

131.31 (v) subject to federal approval, up to an additional five percent of the total rate ~~must~~  
 131.32 may be added to the program rate as a quality incentive based upon the entity meeting  
 131.33 performance criteria specified by the commissioner;

131.34 ~~(3)~~ (2) actual cost is defined as costs which are allowable, allocable, and reasonable,  
 131.35 and consistent with federal reimbursement requirements under Code of Federal

132.1 Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and Office of  
 132.2 Management and Budget Circular Number A-122, relating to nonprofit entities;

132.3 ~~(4)~~ (3) the number of service units;

132.4 ~~(5)~~ (4) the degree to which recipients will receive services other than services under  
 132.5 this section; and

132.6 ~~(6)~~ (5) the costs of other services that will be separately reimbursed; and

132.7 ~~(7)~~ input from the local planning process authorized by the adult mental health  
 132.8 initiative under section 245.4661, regarding recipients' service needs.

132.9 (d) The rate for intensive ~~rehabilitative mental health~~ residential treatment services  
 132.10 and assertive community treatment must exclude room and board, as defined in section  
 132.11 256I.03, subdivision 6, and services not covered under this section, such as partial  
 132.12 hospitalization, home care, and inpatient services.

132.13 (e) Physician services that are not separately billed may be included in the rate to the  
 132.14 extent that a psychiatrist, or other health care professional providing physician services  
 132.15 within their scope of practice, is a member of the treatment team. Physician services,  
 132.16 whether billed separately or included in the rate, may be delivered by telemedicine. For  
 132.17 purposes of this paragraph, "telemedicine" has the meaning given to "mental health  
 132.18 telemedicine" in section 256B.0625, subdivision 46, when telemedicine is used to provide  
 132.19 intensive residential treatment services.

132.20 ~~(e)~~ (f) When services under this section are provided by an ~~intensive nonresidential~~  
 132.21 ~~service~~ assertive community treatment provider, case management functions must be an  
 132.22 integral part of the team.

132.23 ~~(f)~~ (g) The rate for a provider must not exceed the rate charged by that provider for  
 132.24 the same service to other payors.

132.25 ~~(g)~~ (h) The rates for existing programs must be established prospectively based upon  
 132.26 the expenditures and utilization over a prior 12-month period using the criteria established  
 132.27 in paragraph (c). The rates for new programs must be established based upon estimated  
 132.28 expenditures and estimated utilization using the criteria established in paragraph (c).

132.29 ~~(h)~~ (i) Entities who discontinue providing services must be subject to a settle-up  
 132.30 process whereby actual costs and reimbursement for the previous 12 months are  
 132.31 compared. In the event that the entity was paid more than the entity's actual costs plus  
 132.32 any applicable performance-related funding due the provider, the excess payment must  
 132.33 be reimbursed to the department. If a provider's revenue is less than actual allowed costs  
 132.34 due to lower utilization than projected, the commissioner may reimburse the provider to  
 132.35 recover its actual allowable costs. The resulting adjustments by the commissioner must

133.1 be proportional to the percent of total units of service reimbursed by the commissioner  
 133.2 and must reflect a difference of greater than five percent.

133.3 ~~(i)~~ (j) A provider may request of the commissioner a review of any rate-setting  
 133.4 decision made under this subdivision.

133.5 Sec. 27. Minnesota Statutes 2014, section 256B.0622, subdivision 9, is amended to read:

133.6 Subd. 9. **Provider enrollment; rate setting for county-operated entities.** Counties  
 133.7 that employ their own staff to provide services under this section shall apply directly to  
 133.8 the commissioner for enrollment and rate setting. In this case, a county contract is not  
 133.9 required ~~and the commissioner shall perform the program review and rate setting duties~~  
 133.10 ~~which would otherwise be required of counties under this section.~~

133.11 Sec. 28. Minnesota Statutes 2014, section 256B.0622, subdivision 10, is amended to  
 133.12 read:

133.13 Subd. 10. **Provider enrollment; rate setting for specialized program.** A county  
 133.14 contract is not required for a provider proposing to serve a subpopulation of eligible  
 133.15 recipients may bypass the county approval procedures in this section and receive approval  
 133.16 for provider enrollment and rate setting directly from the commissioner under the  
 133.17 following circumstances:

133.18 (1) the provider demonstrates that the subpopulation to be served requires a  
 133.19 specialized program which is not available from county-approved entities; and

133.20 (2) the subpopulation to be served is of such a low incidence that it is not feasible to  
 133.21 develop a program serving a single county or regional group of counties.

133.22 ~~For providers meeting the criteria in clauses (1) and (2), the commissioner shall~~  
 133.23 ~~perform the program review and rate setting duties which would otherwise be required of~~  
 133.24 ~~counties under this section.~~

133.25 Sec. 29. Minnesota Statutes 2014, section 256B.0622, is amended by adding a  
 133.26 subdivision to read:

133.27 Subd. 11. **Sustainability grants.** The commissioner may disburse grant funds  
 133.28 directly to intensive residential treatment services providers and assertive community  
 133.29 treatment providers to maintain access to these services.

133.30 Sec. 30. Minnesota Statutes 2014, section 256B.0624, subdivision 7, is amended to read:

134.1 Subd. 7. **Crisis stabilization services.** (a) Crisis stabilization services must be  
 134.2 provided by qualified staff of a crisis stabilization services provider entity and must meet  
 134.3 the following standards:

134.4 (1) a crisis stabilization treatment plan must be developed which meets the criteria  
 134.5 in subdivision 11;

134.6 (2) staff must be qualified as defined in subdivision 8; and

134.7 (3) services must be delivered according to the treatment plan and include  
 134.8 face-to-face contact with the recipient by qualified staff for further assessment, help with  
 134.9 referrals, updating of the crisis stabilization treatment plan, supportive counseling, skills  
 134.10 training, and collaboration with other service providers in the community.

134.11 (b) If crisis stabilization services are provided in a supervised, licensed residential  
 134.12 setting, the recipient must be contacted face-to-face daily by a qualified mental health  
 134.13 practitioner or mental health professional. The program must have 24-hour-a-day  
 134.14 residential staffing which may include staff who do not meet the qualifications in  
 134.15 subdivision 8. The residential staff must have 24-hour-a-day immediate direct or telephone  
 134.16 access to a qualified mental health professional or practitioner.

134.17 (c) If crisis stabilization services are provided in a supervised, licensed residential  
 134.18 setting that serves no more than four adult residents, and ~~no more than two are recipients~~  
 134.19 ~~of crisis stabilization services~~ one or more individuals are present at the setting to receive  
 134.20 residential crisis stabilization services, the residential staff must include, for at least eight  
 134.21 hours per day, at least one individual who meets the qualifications in subdivision 8,  
 134.22 paragraph (a), clause (1) or (2).

134.23 (d) If crisis stabilization services are provided in a supervised, licensed residential  
 134.24 setting that serves more than four adult residents, and one or more are recipients of crisis  
 134.25 stabilization services, the residential staff must include, for 24 hours a day, at least one  
 134.26 individual who meets the qualifications in subdivision 8. During the first 48 hours that a  
 134.27 recipient is in the residential program, the residential program must have at least two staff  
 134.28 working 24 hours a day. Staffing levels may be adjusted thereafter according to the needs  
 134.29 of the recipient as specified in the crisis stabilization treatment plan.

134.30 Sec. 31. Minnesota Statutes 2014, section 256B.0625, is amended by adding a  
 134.31 subdivision to read:

134.32 Subd. 45a. **Psychiatric residential treatment facility services for persons under**  
 134.33 **21 years of age.** (a) Medical assistance covers psychiatric residential treatment facility  
 134.34 services for persons under 21 years of age. Individuals who reach age 21 at the time they

135.1 are receiving services are eligible to continue receiving services until they no longer  
 135.2 require services or until they reach age 22, whichever occurs first.

135.3 (b) For purposes of this subdivision, "psychiatric residential treatment facility"  
 135.4 means a facility other than a hospital that provides psychiatric services, as described in  
 135.5 Code of Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under  
 135.6 age 21 in an inpatient setting.

135.7 (c) The commissioner shall develop admissions and discharge procedures and  
 135.8 establish rates consistent with guidelines from the federal Centers for Medicare and  
 135.9 Medicaid Services.

135.10 (d) The commissioner shall enroll up to 150 certified psychiatric residential  
 135.11 treatment facility services beds at up to six sites. The commissioner shall select psychiatric  
 135.12 residential treatment facility services providers through a request for proposals process.  
 135.13 Providers of state-operated services may respond to the request for proposals.

135.14 **EFFECTIVE DATE.** This section is effective July 1, 2017, or upon federal  
 135.15 approval, whichever is later. The commissioner of human services shall notify the revisor  
 135.16 of statutes when federal approval is obtained.

135.17 Sec. 32. Minnesota Statutes 2014, section 256B.0625, subdivision 48, is amended to  
 135.18 read:

135.19 Subd. 48. **Psychiatric consultation to primary care practitioners.** Medical  
 135.20 assistance covers consultation provided by a psychiatrist, a psychologist, ~~or~~ an advanced  
 135.21 practice registered nurse certified in psychiatric mental health, a licensed independent  
 135.22 clinical social worker, as defined in section 245.462, subdivision 18, clause (2), or a  
 135.23 licensed marriage and family therapist, as defined in section 245.462, subdivision 18,  
 135.24 clause (5), via telephone, e-mail, facsimile, or other means of communication to primary  
 135.25 care practitioners, including pediatricians. The need for consultation and the receipt of the  
 135.26 consultation must be documented in the patient record maintained by the primary care  
 135.27 practitioner. If the patient consents, and subject to federal limitations and data privacy  
 135.28 provisions, the consultation may be provided without the patient present.

135.29 Sec. 33. **[256B.7631] CHEMICAL DEPENDENCY PROVIDER RATE**  
 135.30 **INCREASE.**

135.31 For the chemical dependency services listed in section 254B.05, subdivision 5, and  
 135.32 provided on or after July 1, 2015, payment rates shall be increased by two percent over  
 135.33 the rates in effect on January 1, 2014, for vendors who meet the requirements of section  
 135.34 254B.05.

136.1       Sec. 34. **CLUBHOUSE PROGRAM SERVICES.**

136.2           The commissioner of human services, in consultation with stakeholders, shall  
136.3 develop service standards and a payment methodology for Clubhouse program services  
136.4 to be covered under medical assistance when provided by a Clubhouse International  
136.5 accredited provider or a provider meeting equivalent standards. The commissioner shall  
136.6 seek federal approval for the service standards and payment methodology. Upon federal  
136.7 approval, the commissioner must seek and obtain legislative approval of the services  
136.8 standards and funding methodology allowing medical assistance coverage of the service.

136.9       Sec. 35. **EXCELLENCE IN MENTAL HEALTH DEMONSTRATION PROJECT.**

136.10          By January 15, 2016, the commissioner of human services shall report to the  
136.11 legislative committees in the house of representatives and senate with jurisdiction over  
136.12 human services issues on the progress of the Excellence in Mental Health demonstration  
136.13 project under Minnesota Statutes, section 245.735. The commissioner shall include in  
136.14 the report any recommendations for legislative changes needed to implement the reform  
136.15 projects specified in Minnesota Statutes, section 245.735, subdivision 4.

136.16       Sec. 36. **RATE-SETTING METHODOLOGY FOR COMMUNITY-BASED**  
136.17 **MENTAL HEALTH SERVICES.**

136.18          The commissioner of human services shall conduct a comprehensive analysis  
136.19 of the current rate-setting methodology for all community-based mental health  
136.20 services for children and adults. The report shall include an assessment of alternative  
136.21 payment structures, consistent with the intent and direction of the federal Centers for  
136.22 Medicare and Medicaid Services, that could provide adequate reimbursement to sustain  
136.23 community-based mental health services regardless of geographic location. The report  
136.24 shall also include recommendations for establishing pay-for-performance measures for  
136.25 providers delivering services consistent with evidence-based practices. In developing the  
136.26 report, the commissioner shall consult with stakeholders and with outside experts in  
136.27 Medicaid financing. The commissioner shall provide a report on the analysis to the chairs  
136.28 of the legislative committees with jurisdiction over health and human services finance  
136.29 by January 1, 2017.

136.30       Sec. 37. **REPORT ON HUMAN SERVICES DATA SHARING TO**  
136.31 **COORDINATE SERVICES AND CARE OF A PATIENT.**

136.32          The commissioner of human services, in coordination with Hennepin County, shall  
136.33 report to the legislative committees with jurisdiction over health care financing on the



137.1 fiscal impact, including the estimated savings, resulting from the modifications to the Data  
 137.2 Practices Act in the 2015 legislative session, permitting the sharing of public welfare data  
 137.3 and allowing the exchange of health records between providers to the extent necessary to  
 137.4 coordinate services and care for clients enrolled in public health care programs. Counties  
 137.5 shall provide information regarding the number of clients receiving care coordination, and  
 137.6 improved outcomes achieved due to data sharing, to the commissioner of human services  
 137.7 to include in the report. The report is due January 1, 2017.

137.8       Sec. 38. **COMPREHENSIVE MENTAL HEALTH PROGRAM IN BELTRAMI**  
 137.9 **COUNTY.**

137.10       (a) The \$500,000 appropriated to the commissioner of human services for a grant to  
 137.11 Beltrami County to fund the planning and development of a comprehensive mental health  
 137.12 program is contingent upon Beltrami County providing to the commissioner of human  
 137.13 services a formal commitment and plan to fund, operate, and sustain the program and  
 137.14 services after the onetime state grant is expended. The county must provide evidence  
 137.15 of the funding stream or mechanism, and a sufficient local funding commitment, that  
 137.16 will ensure that the onetime state investment in the program will result in a sustainable  
 137.17 program without future state grants. The funding stream may include state funding for  
 137.18 programs and services for which the individuals served under this section may be eligible.  
 137.19 The grant under this section cannot be used for any purpose that could be funded with  
 137.20 state bond proceeds. This is a onetime appropriation.

137.21       (b) The planning and development of the program by the county must include an  
 137.22 integrated care model for the provision of mental health and substance use disorder  
 137.23 treatment for the individuals served under paragraph (c), in collaboration with existing  
 137.24 services. The model may include mobile crisis services, crisis residential services,  
 137.25 outpatient services, and community-based services. The model must be patient-centered,  
 137.26 culturally competent, and based on evidence-based practices.

137.27       (c) The comprehensive mental health program will serve individuals who are:  
 137.28       (1) under arrest or subject to arrest who are experiencing a mental health crisis;  
 137.29       (2) under a transport hold under Minnesota Statutes, section 253B.05, subdivision  
 137.30 2; or  
 137.31       (3) in immediate need of mental health crisis services.

137.32       (d) The commissioner of human services may encourage the commissioners of  
 137.33 the Minnesota Housing Finance Agency, corrections, and health to provide technical  
 137.34 assistance and support in the planning and development of the mental health program  
 137.35 under paragraph (a). The commissioners of the Minnesota Housing Finance Agency and

138.1 human services may explore a plan to develop short-term and long-term housing for  
 138.2 individuals served by the program, and the possibility of using existing appropriations  
 138.3 available in the housing finance budget for low-income housing or homelessness.

138.4 (e) The commissioner of human services, in consultation with Beltrami County,  
 138.5 shall report to the senate and house of representatives committees having jurisdiction over  
 138.6 mental health issues the status of the planning and development of the mental health  
 138.7 program, and the plan to financially support the program and services after the state grant  
 138.8 is expended, by November 1, 2017.

### 138.9 **ARTICLE 3**

#### 138.10 **WITHDRAWAL MANAGEMENT PROGRAMS**

##### 138.11 Section 1. **[245F.01] PURPOSE.**

138.12 It is hereby declared to be the public policy of this state that the public interest is best  
 138.13 served by providing efficient and effective withdrawal management services to persons  
 138.14 in need of appropriate detoxification, assessment, intervention, and referral services.  
 138.15 The services shall vary to address the unique medical needs of each patient and shall be  
 138.16 responsive to the language and cultural needs of each patient. Services shall not be denied  
 138.17 on the basis of a patient's inability to pay.

##### 138.18 Sec. 2. **[245F.02] DEFINITIONS.**

138.19 Subdivision 1. **Scope.** The terms used in this chapter have the meanings given  
 138.20 them in this section.

138.21 Subd. 2. **Administration of medications.** "Administration of medications" means  
 138.22 performing a task to provide medications to a patient, and includes the following tasks  
 138.23 performed in the following order:

138.24 (1) checking the patient's medication record;

138.25 (2) preparing the medication for administration;

138.26 (3) administering the medication to the patient;

138.27 (4) documenting administration of the medication or the reason for not administering  
 138.28 the medication as prescribed; and

138.29 (5) reporting information to a licensed practitioner or a registered nurse regarding  
 138.30 problems with the administration of the medication or the patient's refusal to take the  
 138.31 medication.

138.32 Subd. 3. **Alcohol and drug counselor.** "Alcohol and drug counselor" means an  
 138.33 individual qualified under Minnesota Rules, part 9530.6450, subpart 5.

139.1            Subd. 4. **Applicant.** "Applicant" means an individual, partnership, voluntary  
139.2 association, corporation, or other public or private organization that submits an application  
139.3 for licensure under this chapter.

139.4            Subd. 5. **Care coordination.** "Care coordination" means activities intended to bring  
139.5 together health services, patient needs, and streams of information to facilitate the aims  
139.6 of care. Care coordination includes an ongoing needs assessment, life skills advocacy,  
139.7 treatment follow-up, disease management, education, and other services as needed.

139.8            Subd. 6. **Chemical.** "Chemical" means alcohol, solvents, controlled substances as  
139.9 defined in section 152.01, subdivision 4, and other mood-altering substances.

139.10           Subd. 7. **Clinically managed program.** "Clinically managed program" means a  
139.11 residential setting with staff comprised of a medical director and a licensed practical nurse.  
139.12 A licensed practical nurse must be on site 24 hours a day, seven days a week. A qualified  
139.13 medical professional must be available by telephone or in person for consultation 24 hours  
139.14 a day. Patients admitted to this level of service receive medical observation, evaluation,  
139.15 and stabilization services during the detoxification process; access to medications  
139.16 administered by trained, licensed staff to manage withdrawal; and a comprehensive  
139.17 assessment pursuant to Minnesota Rules, part 9530.6422.

139.18           Subd. 8. **Commissioner.** "Commissioner" means the commissioner of human  
139.19 services or the commissioner's designated representative.

139.20           Subd. 9. **Department.** "Department" means the Department of Human Services.

139.21           Subd. 10. **Direct patient contact.** "Direct patient contact" has the meaning given  
139.22 for "direct contact" in section 245C.02, subdivision 11.

139.23           Subd. 11. **Discharge plan.** "Discharge plan" means a written plan that states with  
139.24 specificity the services the program has arranged for the patient to transition back into  
139.25 the community.

139.26           Subd. 12. **Licensed practitioner.** "Licensed practitioner" means a practitioner as  
139.27 defined in section 151.01, subdivision 23, who is authorized to prescribe.

139.28           Subd. 13. **Medical director.** "Medical director" means an individual licensed in  
139.29 Minnesota as a doctor of osteopathy or physician, or an individual licensed in Minnesota  
139.30 as an advanced practice registered nurse by the Board of Nursing and certified to practice  
139.31 as a clinical nurse specialist or nurse practitioner by a national nurse organization  
139.32 acceptable to the board. The medical director must be employed by or under contract with  
139.33 the license holder to direct and supervise health care for patients of a program licensed  
139.34 under this chapter.

139.35           Subd. 14. **Medically monitored program.** "Medically monitored program" means  
139.36 a residential setting with staff that includes a registered nurse and a medical director. A

140.1 registered nurse must be on site 24 hours a day. A medical director must be on site seven  
140.2 days a week, and patients must have the ability to be seen by a medical director within 24  
140.3 hours. Patients admitted to this level of service receive medical observation, evaluation,  
140.4 and stabilization services during the detoxification process; medications administered by  
140.5 trained, licensed staff to manage withdrawal; and a comprehensive assessment pursuant to  
140.6 Minnesota Rules, part 9530.6422.

140.7 Subd. 15. **Nurse.** "Nurse" means a person licensed and currently registered to  
140.8 practice practical or professional nursing as defined in section 148.171, subdivisions  
140.9 14 and 15.

140.10 Subd. 16. **Patient.** "Patient" means an individual who presents or is presented for  
140.11 admission to a withdrawal management program that meets the criteria in section 245F.05.

140.12 Subd. 17. **Peer recovery support services.** "Peer recovery support services"  
140.13 means mentoring and education, advocacy, and nonclinical recovery support provided  
140.14 by a recovery peer.

140.15 Subd. 18. **Program director.** "Program director" means the individual who is  
140.16 designated by the license holder to be responsible for all operations of a withdrawal  
140.17 management program and who meets the qualifications specified in section 245F.15,  
140.18 subdivision 3.

140.19 Subd. 19. **Protective procedure.** "Protective procedure" means an action taken by a  
140.20 staff member of a withdrawal management program to protect a patient from imminent  
140.21 danger of harming self or others. Protective procedures include the following actions:

140.22 (1) seclusion, which means the temporary placement of a patient, without the  
140.23 patient's consent, in an environment to prevent social contact; and

140.24 (2) physical restraint, which means the restraint of a patient by use of physical holds  
140.25 intended to limit movement of the body.

140.26 Subd. 20. **Qualified medical professional.** "Qualified medical professional"  
140.27 means an individual licensed in Minnesota as a doctor of osteopathy or physician, or an  
140.28 individual licensed in Minnesota as an advanced practice registered nurse by the Board of  
140.29 Nursing and certified to practice as a clinical nurse specialist or nurse practitioner by a  
140.30 national nurse organization acceptable to the board.

140.31 Subd. 21. **Recovery peer.** "Recovery peer" means a person who has progressed in  
140.32 the person's own recovery from substance use disorder and is willing to serve as a peer  
140.33 to assist others in their recovery.

140.34 Subd. 22. **Responsible staff person.** "Responsible staff person" means the program  
140.35 director, the medical director, or a staff person with current licensure as a nurse in

141.1 Minnesota. The responsible staff person must be on the premises and is authorized to  
141.2 make immediate decisions concerning patient care and safety.

141.3 Subd. 23. **Substance.** "Substance" means "chemical" as defined in subdivision 6.

141.4 Subd. 24. **Substance use disorder.** "Substance use disorder" means a pattern of  
141.5 substance use as defined in the current edition of the Diagnostic and Statistical Manual of  
141.6 Mental Disorders.

141.7 Subd. 25. **Technician.** "Technician" means a person who meets the qualifications in  
141.8 section 245F.15, subdivision 6.

141.9 Subd. 26. **Withdrawal management program.** "Withdrawal management  
141.10 program" means a licensed program that provides short-term medical services on  
141.11 a 24-hour basis for the purpose of stabilizing intoxicated patients, managing their  
141.12 withdrawal, and facilitating access to substance use disorder treatment as indicated by a  
141.13 comprehensive assessment.

141.14 Sec. 3. **[245F.03] APPLICATION.**

141.15 (a) This chapter establishes minimum standards for withdrawal management  
141.16 programs licensed by the commissioner that serve one or more unrelated persons.

141.17 (b) This chapter does not apply to a withdrawal management program licensed as a  
141.18 hospital under sections 144.50 to 144.581. A withdrawal management program located in  
141.19 a hospital licensed under sections 144.50 to 144.581 that chooses to be licensed under this  
141.20 chapter is deemed to be in compliance with section 245F.13.

141.21 Sec. 4. **[245F.04] PROGRAM LICENSURE.**

141.22 Subdivision 1. **General application and license requirements.** An applicant  
141.23 for licensure as a clinically managed withdrawal management program or medically  
141.24 monitored withdrawal management program must meet the following requirements,  
141.25 except where otherwise noted. All programs must comply with federal requirements and  
141.26 the general requirements in chapters 245A and 245C and sections 626.556, 626.557, and  
141.27 626.5572. A withdrawal management program must be located in a hospital licensed under  
141.28 sections 144.50 to 144.581, or must be a supervised living facility with a class B license  
141.29 from the Department of Health under Minnesota Rules, parts 4665.0100 to 4665.9900.

141.30 Subd. 2. **Contents of application.** Prior to the issuance of a license, an applicant  
141.31 must submit, on forms provided by the commissioner, documentation demonstrating  
141.32 the following:

141.33 (1) compliance with this section;

142.1 (2) compliance with applicable building, fire, and safety codes; health rules; zoning  
142.2 ordinances; and other applicable rules and regulations or documentation that a waiver  
142.3 has been granted. The granting of a waiver does not constitute modification of any  
142.4 requirement of this section;

142.5 (3) completion of an assessment of need for a new or expanded program as required  
142.6 by Minnesota Rules, part 9530.6800; and

142.7 (4) insurance coverage, including bonding, sufficient to cover all patient funds,  
142.8 property, and interests.

142.9 Subd. 3. **Changes in license terms.** (a) A license holder must notify the  
142.10 commissioner before one of the following occurs and the commissioner must determine  
142.11 the need for a new license:

142.12 (1) a change in the Department of Health's licensure of the program;

142.13 (2) a change in the medical services provided by the program that affects the  
142.14 program's capacity to provide services required by the program's license designation as a  
142.15 clinically managed program or medically monitored program;

142.16 (3) a change in program capacity; or

142.17 (4) a change in location.

142.18 (b) A license holder must notify the commissioner and apply for a new license  
142.19 when a change in program ownership occurs.

142.20 Subd. 4. **Variances.** The commissioner may grant variances to the requirements of  
142.21 this chapter under section 245A.04, subdivision 9.

142.22 Sec. 5. **[245F.05] ADMISSION AND DISCHARGE POLICIES.**

142.23 Subdivision 1. **Admission policy.** A license holder must have a written admission  
142.24 policy containing specific admission criteria. The policy must describe the admission  
142.25 process and the point at which an individual who is eligible under subdivision 2 is  
142.26 admitted to the program. A license holder must not admit individuals who do not meet the  
142.27 admission criteria. The admission policy must be approved and signed by the medical  
142.28 director of the facility and must designate which staff members are authorized to admit  
142.29 and discharge patients. The admission policy must be posted in the area of the facility  
142.30 where patients are admitted and given to all interested individuals upon request.

142.31 Subd. 2. **Admission criteria.** For an individual to be admitted to a withdrawal  
142.32 management program, the program must make a determination that the program services  
142.33 are appropriate to the needs of the individual. A program may only admit individuals who  
142.34 meet the admission criteria and who, at the time of admission:

142.35 (1) are impaired as the result of intoxication;

143.1 (2) are experiencing physical, mental, or emotional problems due to intoxication or  
 143.2 withdrawal from alcohol or other drugs;

143.3 (3) are being held under apprehend and hold orders under section 253B.07,  
 143.4 subdivision 2b;

143.5 (4) have been committed under chapter 253B, and need temporary placement;

143.6 (5) are held under emergency holds or peace and health officer holds under section  
 143.7 253B.05, subdivision 1 or 2; or

143.8 (6) need to stay temporarily in a protective environment because of a crisis related  
 143.9 to substance use disorder. Individuals satisfying this clause may be admitted only at the  
 143.10 request of the county of fiscal responsibility, as determined according to section 256G.02,  
 143.11 subdivision 4. Individuals admitted according to this clause must not be restricted to  
 143.12 the facility.

143.13 Subd. 3. **Individuals denied admission by program.** (a) A license holder must  
 143.14 have a written policy and procedure for addressing the needs of individuals who are  
 143.15 denied admission to the program. These individuals include:

143.16 (1) individuals whose pregnancy, in combination with their presenting problem,  
 143.17 requires services not provided by the program; and

143.18 (2) individuals who are in imminent danger of harming self or others if their  
 143.19 behavior is beyond the behavior management capabilities of the program and staff.

143.20 (b) Programs must document denied admissions, including the date and time of  
 143.21 the admission request, reason for the denial of admission, and where the individual was  
 143.22 referred. If the individual did not receive a referral, the program must document why a  
 143.23 referral was not made. This information must be documented on a form approved by the  
 143.24 commissioner and made available to the commissioner upon request.

143.25 Subd. 4. **License holder responsibilities; denying admission or terminating**  
 143.26 **services.** (a) If a license holder denies an individual admission to the program or  
 143.27 terminates services to a patient and the denial or termination poses an immediate threat to  
 143.28 the patient's or individual's health or requires immediate medical intervention, the license  
 143.29 holder must refer the patient or individual to a medical facility capable of admitting the  
 143.30 patient or individual.

143.31 (b) A license holder must report to a law enforcement agency with proper jurisdiction  
 143.32 all denials of admission and terminations of services that involve the commission of a crime  
 143.33 against a staff member of the license holder or on the license holder's property, as provided  
 143.34 in Code of Federal Regulations, title 42, section 2.12(c)(5), and title 45, parts 160 to 164.

143.35 Subd. 5. **Discharge and transfer policies.** A license holder must have a written  
 143.36 policy and procedure, approved and signed by the medical director, that specifies

144.1 conditions under which patients may be discharged or transferred. The policy must  
 144.2 include the following:

144.3 (1) guidelines for determining when a patient is medically stable and whether a  
 144.4 patient is able to be discharged or transferred to a lower level of care;

144.5 (2) guidelines for determining when a patient needs a transfer to a higher level of care.  
 144.6 Clinically managed program guidelines must include guidelines for transfer to a medically  
 144.7 monitored program, hospital, or other acute care facility. Medically monitored program  
 144.8 guidelines must include guidelines for transfer to a hospital or other acute care facility;

144.9 (3) procedures staff must follow when discharging a patient under each of the  
 144.10 following circumstances:

144.11 (i) the patient is involved in the commission of a crime against program staff or  
 144.12 against a license holder's property. The procedures for a patient discharged under this  
 144.13 item must specify how reports must be made to law enforcement agencies with proper  
 144.14 jurisdiction as allowed under Code of Federal Regulations, title 42, section 2.12(c)(5), and  
 144.15 title 45, parts 160 to 164;

144.16 (ii) the patient is in imminent danger of harming self or others and is beyond the  
 144.17 license holder's capacity to ensure safety;

144.18 (iii) the patient was admitted under chapter 253B; or

144.19 (iv) the patient is leaving against staff or medical advice; and

144.20 (4) a requirement that staff must document where the patient was referred after  
 144.21 discharge or transfer, and if a referral was not made, the reason the patient was not  
 144.22 provided a referral.

144.23 **Sec. 6. [245F.06] SCREENING AND COMPREHENSIVE ASSESSMENT.**

144.24 **Subdivision 1. Screening for substance use disorder.** A nurse or an alcohol  
 144.25 and drug counselor must screen each patient upon admission to determine whether a  
 144.26 comprehensive assessment is indicated. The license holder must screen patients at  
 144.27 each admission, except that if the patient has already been determined to suffer from a  
 144.28 substance use disorder, subdivision 2 applies.

144.29 **Subd. 2. Comprehensive assessment.** (a) Prior to a medically stable discharge,  
 144.30 but not later than 72 hours following admission, a license holder must provide a  
 144.31 comprehensive assessment according to section 245.4863, paragraph (a), and Minnesota  
 144.32 Rules, part 9530.6422, for each patient who has a positive screening for a substance use  
 144.33 disorder. If a patient's medical condition prevents a comprehensive assessment from  
 144.34 being completed within 72 hours, the license holder must document why the assessment



145.1 was not completed. The comprehensive assessment must include documentation of the  
145.2 appropriateness of an involuntary referral through the civil commitment process.

145.3 (b) If available to the program, a patient's previous comprehensive assessment may  
145.4 be used in the patient record. If a previously completed comprehensive assessment is used,  
145.5 its contents must be reviewed to ensure the assessment is accurate and current and complies  
145.6 with the requirements of this chapter. The review must be completed by a staff person  
145.7 qualified according to Minnesota Rules, part 9530.6450, subpart 5. The license holder must  
145.8 document that the review was completed and that the previously completed assessment is  
145.9 accurate and current, or the license holder must complete an updated or new assessment.

145.10 **Sec. 7. [245F.07] STABILIZATION PLANNING.**

145.11 Subdivision 1. **Stabilization plan.** Within 12 hours of admission, a license  
145.12 holder must develop an individualized stabilization plan for each patient accepted for  
145.13 stabilization services. The plan must be based on the patient's initial health assessment  
145.14 and continually updated based on new information gathered about the patient's condition  
145.15 from the comprehensive assessment, medical evaluation and consultation, and ongoing  
145.16 monitoring and observations of the patient. The patient must have an opportunity to have  
145.17 direct involvement in the development of the plan. The stabilization plan must:

145.18 (1) identify medical needs and goals to be achieved while the patient is receiving  
145.19 services;

145.20 (2) specify stabilization services to address the identified medical needs and goals,  
145.21 including amount and frequency of services;

145.22 (3) specify the participation of others in the stabilization planning process and  
145.23 specific services where appropriated; and

145.24 (4) document the patient's participation in developing the content of the stabilization  
145.25 plan and any updates.

145.26 Subd. 2. **Progress notes.** Progress notes must be entered in the patient's file at least  
145.27 daily and immediately following any significant event, including any change that impacts  
145.28 the medical, behavioral, or legal status of the patient. Progress notes must:

145.29 (1) include documentation of the patient's involvement in the stabilization services,  
145.30 including the type and amount of each stabilization service;

145.31 (2) include the monitoring and observations of the patient's medical needs;

145.32 (3) include documentation of referrals made to other services or agencies;

145.33 (4) specify the participation of others; and

145.34 (5) be legible, signed, and dated by the staff person completing the documentation.

146.1 Subd. 3. **Discharge plan.** Before a patient leaves the facility, the license holder  
146.2 must conduct discharge planning for the patient, document discharge planning in the  
146.3 patient's record, and provide the patient with a copy of the discharge plan. The discharge  
146.4 plan must include:

- 146.5 (1) referrals made to other services or agencies at the time of transition;  
146.6 (2) the patient's plan for follow-up, aftercare, or other poststabilization services;  
146.7 (3) documentation of the patient's participation in the development of the transition  
146.8 plan;  
146.9 (4) any service that will continue after discharge under the direction of the license  
146.10 holder; and  
146.11 (5) a stabilization summary and final evaluation of the patient's progress toward  
146.12 treatment objectives.

146.13 Sec. 8. **[245F.08] STABILIZATION SERVICES.**

146.14 Subdivision 1. **General.** The license holder must encourage patients to remain in  
146.15 care for an appropriate duration as determined by the patient's stabilization plan, and must  
146.16 encourage all patients to enter programs for ongoing recovery as clinically indicated. In  
146.17 addition, the license holder must offer services that are patient-centered, trauma-informed,  
146.18 and culturally appropriate. Culturally appropriate services must include translation services  
146.19 and dietary services that meet a patient's dietary needs. All services provided to the patient  
146.20 must be documented in the patient's medical record. The following services must be  
146.21 offered unless clinically inappropriate and the justifying clinical rationale is documented:

- 146.22 (1) individual or group motivational counseling sessions;  
146.23 (2) individual advocacy and case management services;  
146.24 (3) medical services as required in section 245F.12;  
146.25 (4) care coordination provided according to subdivision 2;  
146.26 (5) peer recovery support services provided according to subdivision 3;  
146.27 (6) patient education provided according to subdivision 4; and  
146.28 (7) referrals to mutual aid, self-help, and support groups.

146.29 Subd. 2. **Care coordination.** Care coordination services must be initiated for each  
146.30 patient upon admission. The license holder must identify the staff person responsible for  
146.31 the provision of each service. Care coordination services must include:

- 146.32 (1) coordination with significant others to assist in the stabilization planning process  
146.33 whenever possible;  
146.34 (2) coordination with and follow-up to appropriate medical services as identified by  
146.35 the nurse or licensed practitioner;

- 147.1 (3) referral to substance use disorder services as indicated by the comprehensive  
147.2 assessment;
- 147.3 (4) referral to mental health services as identified in the comprehensive assessment;  
147.4 (5) referrals to economic assistance, social services, and prenatal care in accordance  
147.5 with the patient's needs;
- 147.6 (6) review and approval of the transition plan prior to discharge, except in an  
147.7 emergency, by a staff member able to provide direct patient contact;
- 147.8 (7) documentation of the provision of care coordination services in the patient's  
147.9 file; and
- 147.10 (8) addressing cultural and socioeconomic factors affecting the patient's access to  
147.11 services.
- 147.12 Subd. 3. **Peer recovery support services.** (a) Peers in recovery serve as mentors or  
147.13 recovery-support partners for individuals in recovery, and may provide encouragement,  
147.14 self-disclosure of recovery experiences, transportation to appointments, assistance with  
147.15 finding resources that will help locate housing, job search resources, and assistance finding  
147.16 and participating in support groups.
- 147.17 (b) Peer recovery support services are provided by a recovery peer and must be  
147.18 supervised by the responsible staff person.
- 147.19 Subd. 4. **Patient education.** A license holder must provide education to each  
147.20 patient on the following:
- 147.21 (1) substance use disorder, including the effects of alcohol and other drugs, specific  
147.22 information about the effects of substance use on unborn children, and the signs and  
147.23 symptoms of fetal alcohol spectrum disorders;
- 147.24 (2) tuberculosis and reporting known cases of tuberculosis disease to health care  
147.25 authorities according to section 144.4804;
- 147.26 (3) Hepatitis C treatment and prevention;  
147.27 (4) HIV as required in section 245A.19, paragraphs (b) and (c);  
147.28 (5) nicotine cessation options, if applicable;  
147.29 (6) opioid tolerance and overdose risks, if applicable; and  
147.30 (7) long-term withdrawal issues related to use of barbiturates and benzodiazepines,  
147.31 if applicable.
- 147.32 Subd. 5. **Mutual aid, self-help, and support groups.** The license holder must  
147.33 refer patients to mutual aid, self-help, and support groups when clinically indicated and  
147.34 to the extent available in the community.
- 147.35 Sec. 9. **[245F.09] PROTECTIVE PROCEDURES.**

148.1 Subdivision 1. Use of protective procedures. (a) Programs must incorporate  
148.2 person-centered planning and trauma-informed care into its protective procedure policies.  
148.3 Protective procedures may be used only in cases where a less restrictive alternative will  
148.4 not protect the patient or others from harm and when the patient is in imminent danger  
148.5 of harming self or others. When a program uses a protective procedure, the program  
148.6 must continuously observe the patient until the patient may safely be left for 15-minute  
148.7 intervals. Use of the procedure must end when the patient is no longer in imminent danger  
148.8 of harming self or others.

148.9 (b) Protective procedures may not be used:

148.10 (1) for disciplinary purposes;

148.11 (2) to enforce program rules;

148.12 (3) for the convenience of staff;

148.13 (4) as a part of any patient's health monitoring plan; or

148.14 (5) for any reason except in response to specific, current behaviors which create an  
148.15 imminent danger of harm to the patient or others.

148.16 Subd. 2. Protective procedures plan. A license holder must have a written policy  
148.17 and procedure that establishes the protective procedures that program staff must follow  
148.18 when a patient is in imminent danger of harming self or others. The policy must be  
148.19 appropriate to the type of facility and the level of staff training. The protective procedures  
148.20 policy must include:

148.21 (1) an approval signed and dated by the program director and medical director prior  
148.22 to implementation. Any changes to the policy must also be approved, signed, and dated by  
148.23 the current program director and the medical director prior to implementation;

148.24 (2) which protective procedures the license holder will use to prevent patients from  
148.25 imminent danger of harming self or others;

148.26 (3) the emergency conditions under which the protective procedures are permitted  
148.27 to be used, if any;

148.28 (4) the patient's health conditions that limit the specific procedures that may be used  
148.29 and alternative means of ensuring safety;

148.30 (5) emergency resources the program staff must contact when a patient's behavior  
148.31 cannot be controlled by the procedures established in the policy;

148.32 (6) the training that staff must have before using any protective procedure;

148.33 (7) documentation of approved therapeutic holds;

148.34 (8) the use of law enforcement personnel as described in subdivision 4;

149.1 (9) standards governing emergency use of seclusion. Seclusion must be used only  
149.2 when less restrictive measures are ineffective or not feasible. The standards in items (i) to  
149.3 (vii) must be met when seclusion is used with a patient:

149.4 (i) seclusion must be employed solely for the purpose of preventing a patient from  
149.5 imminent danger of harming self or others;

149.6 (ii) seclusion rooms must be equipped in a manner that prevents patients from  
149.7 self-harm using projections, windows, electrical fixtures, or hard objects, and must allow  
149.8 the patient to be readily observed without being interrupted;

149.9 (iii) seclusion must be authorized by the program director, a licensed physician, or  
149.10 a registered nurse. If one of these individuals is not present in the facility, the program  
149.11 director or a licensed physician or registered nurse must be contacted and authorization  
149.12 must be obtained within 30 minutes of initiating seclusion, according to written policies;

149.13 (iv) patients must not be placed in seclusion for more than 12 hours at any one time;

149.14 (v) once the condition of a patient in seclusion has been determined to be safe  
149.15 enough to end continuous observation, a patient in seclusion must be observed at a  
149.16 minimum of every 15 minutes for the duration of seclusion and must always be within  
149.17 hearing range of program staff;

149.18 (vi) a process for program staff to use to remove a patient to other resources available  
149.19 to the facility if seclusion does not sufficiently assure patient safety; and

149.20 (vii) a seclusion area may be used for other purposes, such as intensive observation, if  
149.21 the room meets normal standards of care for the purpose and if the room is not locked; and

149.22 (10) physical holds may only be used when less restrictive measures are not feasible.

149.23 The standards in items (i) to (iv) must be met when physical holds are used with a patient:

149.24 (i) physical holds must be employed solely for preventing a patient from imminent  
149.25 danger of harming self or others;

149.26 (ii) physical holds must be authorized by the program director, a licensed physician,  
149.27 or a registered nurse. If one of these individuals is not present in the facility, the program  
149.28 director or a licensed physician or a registered nurse must be contacted and authorization  
149.29 must be obtained within 30 minutes of initiating a physical hold, according to written  
149.30 policies;

149.31 (iii) the patient's health concerns must be considered in deciding whether to use  
149.32 physical holds and which holds are appropriate for the patient; and

149.33 (iv) only approved holds may be utilized. Prone holds are not allowed and must  
149.34 not be authorized.

149.35 Subd. 3. **Records.** Each use of a protective procedure must be documented in the  
149.36 patient record. The patient record must include:

- 150.1 (1) a description of specific patient behavior precipitating a decision to use a  
 150.2 protective procedure, including date, time, and program staff present;
- 150.3 (2) the specific means used to limit the patient's behavior;
- 150.4 (3) the time the protective procedure began, the time the protective procedure ended,  
 150.5 and the time of each staff observation of the patient during the procedure;
- 150.6 (4) the names of the program staff authorizing the use of the protective procedure,  
 150.7 the time of the authorization, and the program staff directly involved in the protective  
 150.8 procedure and the observation process;
- 150.9 (5) a brief description of the purpose for using the protective procedure, including  
 150.10 less restrictive interventions used prior to the decision to use the protective procedure  
 150.11 and a description of the behavioral results obtained through the use of the procedure. If  
 150.12 a less restrictive intervention was not used, the reasons for not using a less restrictive  
 150.13 intervention must be documented;
- 150.14 (6) documentation by the responsible staff person on duty of reassessment of the  
 150.15 patient at least every 15 minutes to determine if seclusion or the physical hold can be  
 150.16 terminated;
- 150.17 (7) a description of the physical holds used in escorting a patient; and
- 150.18 (8) any injury to the patient that occurred during the use of a protective procedure.
- 150.19 **Subd. 4. Use of law enforcement.** The program must maintain a central log  
 150.20 documenting each incident involving use of law enforcement, including:
- 150.21 (1) the date and time law enforcement arrived at and left the program;
- 150.22 (2) the reason for the use of law enforcement;
- 150.23 (3) if law enforcement used force or a protective procedure and which protective  
 150.24 procedure was used; and
- 150.25 (4) whether any injuries occurred.
- 150.26 **Subd. 5. Administrative review.** (a) The license holder must keep a record of all  
 150.27 patient incidents and protective procedures used. An administrative review of each use  
 150.28 of protective procedures must be completed within 72 hours by someone other than the  
 150.29 person who used the protective procedure. The record of the administrative review of the  
 150.30 use of protective procedures must state whether:
- 150.31 (1) the required documentation was recorded for each use of a protective procedure;
- 150.32 (2) the protective procedure was used according to the policy and procedures;
- 150.33 (3) the staff who implemented the protective procedure was properly trained; and
- 150.34 (4) the behavior met the standards for imminent danger of harming self or others.

151.1 (b) The license holder must conduct and document a quarterly review of the use of  
 151.2 protective procedures with the goal of reducing the use of protective procedures. The  
 151.3 review must include:

151.4 (1) any patterns or problems indicated by similarities in the time of day, day of the  
 151.5 week, duration of the use of a protective procedure, individuals involved, or other factors  
 151.6 associated with the use of protective procedures;

151.7 (2) any injuries resulting from the use of protective procedures;

151.8 (3) whether law enforcement was involved in the use of a protective procedure;

151.9 (4) actions needed to correct deficiencies in the program's implementation of  
 151.10 protective procedures;

151.11 (5) an assessment of opportunities missed to avoid the use of protective procedures;

151.12 and

151.13 (6) proposed actions to be taken to minimize the use of protective procedures.

151.14 Sec. 10. **[245F.10] PATIENT RIGHTS AND GRIEVANCE PROCEDURES.**

151.15 Subdivision 1. **Patient rights.** Patients have the rights in sections 144.651,  
 151.16 148F.165, and 253B.03, as applicable. The license holder must give each patient, upon  
 151.17 admission, a written statement of patient rights. Program staff must review the statement  
 151.18 with the patient.

151.19 Subd. 2. **Grievance procedure.** Upon admission, the license holder must explain  
 151.20 the grievance procedure to the patient or patient's representative and give the patient a  
 151.21 written copy of the procedure. The grievance procedure must be posted in a place visible  
 151.22 to the patient and must be made available to current and former patients upon request. A  
 151.23 license holder's written grievance procedure must include:

151.24 (1) staff assistance in developing and processing the grievance;

151.25 (2) an initial response to the patient who filed the grievance within 24 hours of the  
 151.26 program's receipt of the grievance, and timelines for additional steps to be taken to resolve  
 151.27 the grievance, including access to the person with the highest level of authority in the  
 151.28 program if the grievance cannot be resolved by other staff members; and

151.29 (3) the addresses and telephone numbers of the Department of Human Services  
 151.30 Licensing Division, Department of Health Office of Health Facilities Complaints, Board  
 151.31 of Behavioral Health and Therapy, Board of Medical Practice, Board of Nursing, and  
 151.32 Office of the Ombudsman for Mental Health and Developmental Disabilities.

151.33 Sec. 11. **[245F.11] PATIENT PROPERTY MANAGEMENT.**

152.1 A license holder must meet the requirements for handling patient funds and property  
 152.2 in section 245A.04, subdivision 14, except:

152.3 (1) a license holder must establish policies regarding the use of personal property to  
 152.4 assure that program activities and the rights of other patients are not infringed, and may  
 152.5 take temporary custody of personal property if these policies are violated;

152.6 (2) a license holder must retain the patient's property for a minimum of seven days  
 152.7 after discharge if the patient does not reclaim the property after discharge; and

152.8 (3) the license holder must return to the patient all of the patient's property held in  
 152.9 trust at discharge, regardless of discharge status, except that:

152.10 (i) drugs, drug paraphernalia, and drug containers that are subject to forfeiture under  
 152.11 section 609.5316 must be given over to the custody of a local law enforcement agency or,  
 152.12 if giving the property over to the custody of a local law enforcement agency would violate  
 152.13 Code of Federal Regulations, title 42, sections 2.1 to 2.67, and title 45, parts 160 to 164,  
 152.14 destroyed by a staff person designated by the program director; and

152.15 (ii) weapons, explosives, and other property that may cause serious harm to self  
 152.16 or others must be transferred to a local law enforcement agency. The patient must be  
 152.17 notified of the transfer and the right to reclaim the property if the patient has a legal right  
 152.18 to possess the item.

152.19 Sec. 12. **[245F.12] MEDICAL SERVICES.**

152.20 Subdivision 1. **Services provided at all programs.** Withdrawal management  
 152.21 programs must have:

152.22 (1) a standardized data collection tool for collecting health-related information about  
 152.23 each patient. The data collection tool must be developed in collaboration with a registered  
 152.24 nurse and approved and signed by the medical director; and

152.25 (2) written procedures for a nurse to assess and monitor patient health within the  
 152.26 nurse's scope of practice. The procedures must:

152.27 (i) be approved by the medical director;

152.28 (ii) include a follow-up screening conducted between four and 12 hours after service  
 152.29 initiation to collect information relating to acute intoxication, other health complaints, and  
 152.30 behavioral risk factors that the patient may not have communicated at service initiation;

152.31 (iii) specify the physical signs and symptoms that, when present, require consultation  
 152.32 with a registered nurse or a physician and that require transfer to an acute care facility or  
 152.33 a higher level of care than that provided by the program;

152.34 (iv) specify those staff members responsible for monitoring patient health and  
 152.35 provide for hourly observation and for more frequent observation if the initial health



153.1 assessment or follow-up screening indicates a need for intensive physical or behavioral  
 153.2 health monitoring; and  
 153.3 (v) specify the actions to be taken to address specific complicating conditions,  
 153.4 including pregnancy or the presence of physical signs or symptoms of any other medical  
 153.5 condition.

153.6 Subd. 2. **Services provided at clinically managed programs.** In addition to the  
 153.7 services listed in subdivision 1, clinically managed programs must:

153.8 (1) have a licensed practical nurse on site 24 hours a day and a medical director;

153.9 (2) provide an initial health assessment conducted by a nurse upon admission;

153.10 (3) provide daily on-site medical evaluation and consultation with a registered  
 153.11 nurse and have a registered nurse available by telephone or in person for consultation  
 153.12 24 hours a day;

153.13 (4) have a qualified medical professional available by telephone or in person for  
 153.14 consultation 24 hours a day; and

153.15 (5) have appropriately licensed staff available to administer medications according  
 153.16 to prescriber-approved orders.

153.17 Subd. 3. **Services provided at medically monitored programs.** In addition to the  
 153.18 services listed in subdivision 1, medically monitored programs must have a registered  
 153.19 nurse on site 24 hours a day and a medical director. Medically monitored programs must  
 153.20 provide intensive inpatient withdrawal management services which must include:

153.21 (1) an initial health assessment conducted by a registered nurse upon admission;

153.22 (2) the availability of a medical evaluation and consultation with a registered nurse  
 153.23 24 hours a day;

153.24 (3) the availability of a qualified medical professional by telephone or in person  
 153.25 for consultation 24 hours a day;

153.26 (4) the ability to be seen within 24 hours or sooner by a qualified medical  
 153.27 professional if the initial health assessment indicates the need to be seen;

153.28 (5) the availability of on-site monitoring of patient care seven days a week by a  
 153.29 qualified medical professional; and

153.30 (6) appropriately licensed staff available to administer medications according to  
 153.31 prescriber-approved orders.

153.32 **Sec. 13. [245F.13] MEDICATIONS.**

153.33 Subdivision 1. **Administration of medications.** A license holder must employ or  
 153.34 contract with a registered nurse to develop the policies and procedures for medication  
 153.35 administration. A registered nurse must provide supervision as defined in section 148.171,

154.1 subdivision 23, for the administration of medications. For clinically managed programs,  
154.2 the registered nurse supervision must include on-site supervision at least monthly or more  
154.3 often as warranted by the health needs of the patient. The medication administration  
154.4 policies and procedures must include:

154.5 (1) a provision that patients may carry emergency medication such as nitroglycerin  
154.6 as instructed by their prescriber;

154.7 (2) requirements for recording the patient's use of medication, including staff  
154.8 signatures with date and time;

154.9 (3) guidelines regarding when to inform a licensed practitioner or a registered nurse  
154.10 of problems with medication administration, including failure to administer, patient  
154.11 refusal of a medication, adverse reactions, or errors; and

154.12 (4) procedures for acceptance, documentation, and implementation of prescriptions,  
154.13 whether written, oral, telephonic, or electronic.

154.14 Subd. 2. **Control of drugs.** A license holder must have in place and implement  
154.15 written policies and procedures relating to control of drugs. The policies and procedures  
154.16 must be developed by a registered nurse and must contain the following provisions:

154.17 (1) a requirement that all drugs must be stored in a locked compartment. Schedule II  
154.18 drugs, as defined in section 152.02, subdivision 3, must be stored in a separately locked  
154.19 compartment that is permanently affixed to the physical plant or a medication cart;

154.20 (2) a system for accounting for all scheduled drugs each shift;

154.21 (3) a procedure for recording a patient's use of medication, including staff signatures  
154.22 with time and date;

154.23 (4) a procedure for destruction of discontinued, outdated, or deteriorated medications;

154.24 (5) a statement that only authorized personnel are permitted to have access to the  
154.25 keys to the locked drug compartments; and

154.26 (6) a statement that no legend drug supply for one patient may be given to another  
154.27 patient.

154.28 **Sec. 14. [245F.14] STAFFING REQUIREMENTS AND DUTIES.**

154.29 Subdivision 1. **Program director.** A license holder must employ or contract with a  
154.30 person, on a full-time basis, to serve as program director. The program director must be  
154.31 responsible for all aspects of the facility and the services delivered to the license holder's  
154.32 patients. An individual may serve as program director for more than one program owned  
154.33 by the same license holder.

154.34 Subd. 2. **Responsible staff person.** During all hours of operation, a license holder  
154.35 must designate a staff member as the responsible staff person to be present and awake

155.1 in the facility and be responsible for the program. The responsible staff person must  
155.2 have decision-making authority over the day-to-day operation of the program as well  
155.3 as the authority to direct the activity of or terminate the shift of any staff member who  
155.4 has direct patient contact.

155.5 Subd. 3. **Technician required.** A license holder must have one technician awake  
155.6 and on duty at all times for every ten patients in the program. A license holder may assign  
155.7 technicians according to the need for care of the patients, except that the same technician  
155.8 must not be responsible for more than 15 patients at one time. For purposes of establishing  
155.9 this ratio, all staff whose qualifications meet or exceed those for technicians under section  
155.10 245F.15, subdivision 6, and who are performing the duties of a technician may be counted  
155.11 as technicians. The same individual may not be counted as both a technician and an  
155.12 alcohol and drug counselor.

155.13 Subd. 4. **Registered nurse required.** A license holder must employ or contract  
155.14 with a registered nurse, who must be available 24 hours a day by telephone or in person  
155.15 for consultation. The registered nurse is responsible for:

155.16 (1) establishing and implementing procedures for the provision of nursing care and  
155.17 delegated medical care, including:

155.18 (i) a health monitoring plan;

155.19 (ii) a medication control plan;

155.20 (iii) training and competency evaluations for staff performing delegated medical and  
155.21 nursing functions;

155.22 (iv) handling serious illness, accident, or injury to patients;

155.23 (v) an infection control program; and

155.24 (vi) a first aid kit;

155.25 (2) delegating nursing functions to other staff consistent with their education,  
155.26 competence, and legal authorization;

155.27 (3) assigning, supervising, and evaluating the performance of nursing tasks; and

155.28 (4) implementing condition-specific protocols in compliance with section 151.37,  
155.29 subdivision 2.

155.30 Subd. 5. **Medical director required.** A license holder must have a medical director  
155.31 available for medical supervision. The medical director is responsible for ensuring the  
155.32 accurate and safe provision of all health-related services and procedures. A license  
155.33 holder must obtain and document the medical director's annual approval of the following  
155.34 procedures before the procedures may be used:

155.35 (1) admission, discharge, and transfer criteria and procedures;

155.36 (2) a health services plan;

156.1 (3) physical indicators for a referral to a physician, registered nurse, or hospital, and  
156.2 procedures for referral;

156.3 (4) procedures to follow in case of accident, injury, or death of a patient;

156.4 (5) formulation of condition-specific protocols regarding the medications that  
156.5 require a withdrawal regimen that will be administered to patients;

156.6 (6) an infection control program;

156.7 (7) protective procedures; and

156.8 (8) a medication control plan.

156.9 Subd. 6. **Alcohol and drug counselor.** A withdrawal management program must  
156.10 provide one full-time equivalent alcohol and drug counselor for every 16 patients served  
156.11 by the program.

156.12 Subd. 7. **Ensuring staff-to-patient ratio.** The responsible staff person under  
156.13 subdivision 2 must ensure that the program does not exceed the staff-to-patient ratios in  
156.14 subdivisions 3 and 6 and must inform admitting staff of the current staffed capacity of  
156.15 the program for that shift. A license holder must have a written policy for documenting  
156.16 staff-to-patient ratios for each shift and actions to take when staffed capacity is reached.

156.17 Sec. 15. **[245F.15] STAFF QUALIFICATIONS.**

156.18 Subdivision 1. **Qualifications for all staff who have direct patient contact.** (a) All  
156.19 staff who have direct patient contact must be at least 18 years of age and must, at the time  
156.20 of hiring, document that they meet the requirements in paragraph (b), (c), or (d).

156.21 (b) Program directors, supervisors, nurses, and alcohol and drug counselors must be  
156.22 free of substance use problems for at least two years immediately preceding their hiring  
156.23 and must sign a statement attesting to that fact.

156.24 (c) Recovery peers must be free of substance use problems for at least one year  
156.25 immediately preceding their hiring and must sign a statement attesting to that fact.

156.26 (d) Technicians and other support staff must be free of substance use problems  
156.27 for at least six months immediately preceding their hiring and must sign a statement  
156.28 attesting to that fact.

156.29 Subd. 2. **Continuing employment; no substance use problems.** License holders  
156.30 must require staff to be free from substance use problems as a condition of continuing  
156.31 employment. Staff are not required to sign statements attesting to their freedom from  
156.32 substance use problems after the initial statement required by subdivision 1. Staff with  
156.33 substance use problems must be immediately removed from any responsibilities that  
156.34 include direct patient contact.

156.35 Subd. 3. **Program director qualifications.** A program director must:

157.1 (1) have at least one year of work experience in direct service to individuals  
157.2 with substance use disorders or one year of work experience in the management or  
157.3 administration of direct service to individuals with substance use disorders;

157.4 (2) have a baccalaureate degree or three years of work experience in administration  
157.5 or personnel supervision in human services; and

157.6 (3) know and understand the requirements of this chapter and chapters 245A and  
157.7 245C, and sections 253B.04, 253B.05, 626.556, 626.557, and 626.5572.

157.8 Subd. 4. **Alcohol and drug counselor qualifications.** An alcohol and drug  
157.9 counselor must meet the requirements in Minnesota Rules, part 9530.6450, subpart 5.

157.10 Subd. 5. **Responsible staff person qualifications.** Each responsible staff person  
157.11 must know and understand the requirements of this chapter and sections 245A.65,  
157.12 253B.04, 253B.05, 626.556, 626.557, and 626.5572. In a clinically managed program, the  
157.13 responsible staff person must be a licensed practical nurse employed by or under contract  
157.14 with the license holder. In a medically monitored program, the responsible staff person  
157.15 must be a registered nurse, program director, or physician.

157.16 Subd. 6. **Technician qualifications.** A technician employed by a program must  
157.17 demonstrate competency, prior to direct patient contact, in the following areas:

157.18 (1) knowledge of the client bill of rights in section 148F.165, and staff responsibilities  
157.19 in sections 144.651 and 253B.03;

157.20 (2) knowledge of and the ability to perform basic health screening procedures with  
157.21 intoxicated patients that consist of:

157.22 (i) blood pressure, pulse, temperature, and respiration readings;

157.23 (ii) interviewing to obtain relevant medical history and current health complaints; and

157.24 (iii) visual observation of a patient's health status, including monitoring a patient's  
157.25 behavior as it relates to health status;

157.26 (3) a current first aid certificate from the American Red Cross or an equivalent  
157.27 organization; a current cardiopulmonary resuscitation certificate from the American Red  
157.28 Cross, the American Heart Association, a community organization, or an equivalent  
157.29 organization; and knowledge of first aid for seizures, trauma, and loss of consciousness; and

157.30 (4) knowledge of and ability to perform basic activities of daily living and personal  
157.31 hygiene.

157.32 Subd. 7. **Recovering peer qualifications.** Recovery peers must:

157.33 (1) be at least 21 years of age and have a high school diploma or its equivalent;

157.34 (2) have a minimum of one year in recovery from substance use disorder;

158.1 (3) have completed a curriculum designated by the commissioner that teaches  
 158.2 specific skills and training in the domains of ethics and boundaries, advocacy, mentoring  
 158.3 and education, and recovery and wellness support; and

158.4 (4) receive supervision in areas specific to the domains of their role by qualified  
 158.5 supervisory staff.

158.6 Subd. 8. **Personal relationships.** A license holder must have a written policy  
 158.7 addressing personal relationships between patients and staff who have direct patient  
 158.8 contact. The policy must:

158.9 (1) prohibit direct patient contact between a patient and a staff member if the staff  
 158.10 member has had a personal relationship with the patient within two years prior to the  
 158.11 patient's admission to the program;

158.12 (2) prohibit access to a patient's clinical records by a staff member who has had a  
 158.13 personal relationship with the patient within two years prior to the patient's admission,  
 158.14 unless the patient consents in writing; and

158.15 (3) prohibit a clinical relationship between a staff member and a patient if the staff  
 158.16 member has had a personal relationship with the patient within two years prior to the  
 158.17 patient's admission. If a personal relationship exists, the staff member must report the  
 158.18 relationship to the staff member's supervisor and recuse the staff member from a clinical  
 158.19 relationship with that patient.

158.20 Sec. 16. **[245F.16] PERSONNEL POLICIES AND PROCEDURES.**

158.21 Subdivision 1. **Policy requirements.** A license holder must have written personnel  
 158.22 policies and must make them available to staff members at all times. The personnel  
 158.23 policies must:

158.24 (1) ensure that staff member's retention, promotion, job assignment, or pay are not  
 158.25 affected by a good faith communication between the staff member and the Department  
 158.26 of Human Services, Department of Health, Ombudsman for Mental Health and  
 158.27 Developmental Disabilities, law enforcement, or local agencies that investigate complaints  
 158.28 regarding patient rights, health, or safety;

158.29 (2) include a job description for each position that specifies job responsibilities,  
 158.30 degree of authority to execute job responsibilities, standards of job performance related to  
 158.31 specified job responsibilities, and qualifications;

158.32 (3) provide for written job performance evaluations for staff members of the license  
 158.33 holder at least annually;

158.34 (4) describe behavior that constitutes grounds for disciplinary action, suspension, or  
 158.35 dismissal, including policies that address substance use problems and meet the requirements

159.1 of section 245F.15, subdivisions 1 and 2. The policies and procedures must list behaviors  
159.2 or incidents that are considered substance use problems. The list must include:

159.3 (i) receiving treatment for substance use disorder within the period specified for the  
159.4 position in the staff qualification requirements;

159.5 (ii) substance use that has a negative impact on the staff member's job performance;

159.6 (iii) substance use that affects the credibility of treatment services with patients,  
159.7 referral sources, or other members of the community; and

159.8 (iv) symptoms of intoxication or withdrawal on the job;

159.9 (5) include policies prohibiting personal involvement with patients and policies  
159.10 prohibiting patient maltreatment as specified under chapter 604 and sections 245A.65,  
159.11 626.556, 626.557, and 626.5572;

159.12 (6) include a chart or description of organizational structure indicating the lines  
159.13 of authority and responsibilities;

159.14 (7) include a written plan for new staff member orientation that, at a minimum,  
159.15 includes training related to the specific job functions for which the staff member was hired,  
159.16 program policies and procedures, patient needs, and the areas identified in subdivision 2,  
159.17 paragraphs (b) to (e); and

159.18 (8) include a policy on the confidentiality of patient information.

159.19 Subd. 2. **Staff development.** (a) A license holder must ensure that each staff  
159.20 member receives orientation training before providing direct patient care and at least  
159.21 30 hours of continuing education every two years. A written record must be kept to  
159.22 demonstrate completion of training requirements.

159.23 (b) Within 72 hours of beginning employment, all staff having direct patient contact  
159.24 must be provided orientation on the following:

159.25 (1) specific license holder and staff responsibilities for patient confidentiality;

159.26 (2) standards governing the use of protective procedures;

159.27 (3) patient ethical boundaries and patient rights, including the rights of patients  
159.28 admitted under chapter 253B;

159.29 (4) infection control procedures;

159.30 (5) mandatory reporting under sections 245A.65, 626.556, and 626.557, including  
159.31 specific training covering the facility's policies concerning obtaining patient releases  
159.32 of information;

159.33 (6) HIV minimum standards as required in section 245A.19;

159.34 (7) motivational counseling techniques and identifying stages of change; and

159.35 (8) eight hours of training on the program's protective procedures policy required in  
159.36 section 245F.09, including:

- 160.1 (i) approved therapeutic holds;
- 160.2 (ii) protective procedures used to prevent patients from imminent danger of harming
- 160.3 self or others;
- 160.4 (iii) the emergency conditions under which the protective procedures may be used, if
- 160.5 any;
- 160.6 (iv) documentation standards for using protective procedures;
- 160.7 (v) how to monitor and respond to patient distress; and
- 160.8 (vi) person-centered planning and trauma-informed care.
- 160.9 (c) All staff having direct patient contact must be provided annual training on the
- 160.10 following:
- 160.11 (1) infection control procedures;
- 160.12 (2) mandatory reporting under sections 245A.65, 626.556, and 626.557, including
- 160.13 specific training covering the facility's policies concerning obtaining patient releases
- 160.14 of information;
- 160.15 (3) HIV minimum standards as required in section 245A.19; and
- 160.16 (4) motivational counseling techniques and identifying stages of change.
- 160.17 (d) All staff having direct patient contact must be provided training every two
- 160.18 years on the following:
- 160.19 (1) specific license holder and staff responsibilities for patient confidentiality;
- 160.20 (2) standards governing use of protective procedures, including:
- 160.21 (i) approved therapeutic holds;
- 160.22 (ii) protective procedures used to prevent patients from imminent danger of harming
- 160.23 self or others;
- 160.24 (iii) the emergency conditions under which the protective procedures may be used, if
- 160.25 any;
- 160.26 (iv) documentation standards for using protective procedures;
- 160.27 (v) how to monitor and respond to patient distress; and
- 160.28 (vi) person-centered planning and trauma-informed care; and
- 160.29 (3) patient ethical boundaries and patient rights, including the rights of patients
- 160.30 admitted under chapter 253B.
- 160.31 (e) Continuing education that is completed in areas outside of the required topics
- 160.32 must provide information to the staff person that is useful to the performance of the
- 160.33 individual staff person's duties.

160.34 Sec. 17. **[245F.17] PERSONNEL FILES.**



161.1 A license holder must maintain a separate personnel file for each staff member. At a  
 161.2 minimum, the file must contain:

161.3 (1) a completed application for employment signed by the staff member that  
 161.4 contains the staff member's qualifications for employment and documentation related to  
 161.5 the applicant's background study data, as defined in chapter 245C;

161.6 (2) documentation of the staff member's current professional license or registration,  
 161.7 if relevant;

161.8 (3) documentation of orientation and subsequent training;

161.9 (4) documentation of a statement of freedom from substance use problems; and

161.10 (5) an annual job performance evaluation.

161.11 **Sec. 18. [245F.18] POLICY AND PROCEDURES MANUAL.**

161.12 A license holder must develop a written policy and procedures manual that is  
 161.13 alphabetically indexed and has a table of contents, so that staff have immediate access  
 161.14 to all policies and procedures, and that consumers of the services, and other authorized  
 161.15 parties have access to all policies and procedures. The manual must contain the following  
 161.16 materials:

161.17 (1) a description of patient education services as required in section 245F.06;

161.18 (2) personnel policies that comply with section 245F.16;

161.19 (3) admission information and referral and discharge policies that comply with  
 161.20 section 245F.05;

161.21 (4) a health monitoring plan that complies with section 245F.12;

161.22 (5) a protective procedures policy that complies with section 245F.09, if the program  
 161.23 elects to use protective procedures;

161.24 (6) policies and procedures for assuring appropriate patient-to-staff ratios that  
 161.25 comply with section 245F.14;

161.26 (7) policies and procedures for assessing and documenting the susceptibility for  
 161.27 risk of abuse to the patient as the basis for the individual abuse prevention plan required  
 161.28 by section 245A.65;

161.29 (8) procedures for mandatory reporting as required by sections 245A.65, 626.556,  
 161.30 and 626.557;

161.31 (9) a medication control plan that complies with section 245F.13; and

161.32 (10) policies and procedures regarding HIV that meet the minimum standards  
 161.33 under section 245A.19.

161.34 **Sec. 19. [245F.19] PATIENT RECORDS.**

162.1 Subdivision 1. **Patient records required.** A license holder must maintain a file of  
162.2 current patient records on the program premises where the treatment is provided. Each  
162.3 entry in each patient record must be signed and dated by the staff member making the  
162.4 entry. Patient records must be protected against loss, tampering, or unauthorized disclosure  
162.5 in compliance with chapter 13 and section 254A.09; Code of Federal Regulations, title 42,  
162.6 sections 2.1 to 2.67; and title 45, parts 160 to 164.

162.7 Subd. 2. **Records retention.** A license holder must retain and store records as  
162.8 required by section 245A.041, subdivisions 3 and 4.

162.9 Subd. 3. **Contents of records.** Patient records must include the following:

162.10 (1) documentation of the patient's presenting problem, any substance use screening,  
162.11 the most recent assessment, and any updates;

162.12 (2) a stabilization plan and progress notes as required by section 245F.07,  
162.13 subdivisions 1 and 2;

162.14 (3) a discharge summary as required by section 245F.07, subdivision 3;

162.15 (4) an individual abuse prevention plan that complies with section 245A.65, and  
162.16 related rules;

162.17 (5) documentation of referrals made; and

162.18 (6) documentation of the monitoring and observations of the patient's medical needs.

162.19 **Sec. 20. [245F.20] DATA COLLECTION REQUIRED.**

162.20 The license holder must participate in the drug and alcohol abuse normative  
162.21 evaluation system (DAANES) by submitting, in a format provided by the commissioner,  
162.22 information concerning each patient admitted to the program. Staff submitting data must  
162.23 be trained by the license holder with the DAANES Web manual.

162.24 **Sec. 21. [245F.21] PAYMENT METHODOLOGY.**

162.25 The commissioner shall develop a payment methodology for services provided  
162.26 under this chapter or by an Indian Health Services facility or a facility owned and operated  
162.27 by a tribe or tribal organization operating under Public Law 93-638 as a 638 facility. The  
162.28 commissioner shall seek federal approval for the methodology. Upon federal approval, the  
162.29 commissioner must seek and obtain legislative approval of the funding methodology to  
162.30 support the service.

163.1 **ARTICLE 4**

163.2 **DIRECT CARE AND TREATMENT**

163.3 Section 1. Minnesota Statutes 2014, section 43A.241, is amended to read:

163.4 **43A.241 INSURANCE CONTRIBUTIONS; FORMER CORRECTIONS**  
 163.5 **EMPLOYEES.**

163.6 (a) This section applies to a person who:

163.7 (1) ~~was employed by the commissioner of the Department of Corrections at a state~~  
 163.8 ~~institution under control of the commissioner, and in that employment was a member~~  
 163.9 ~~of the general plan of the Minnesota State Retirement System; or by the Department~~  
 163.10 ~~of Human Services;~~

163.11 (2) was covered by the correctional employee retirement plan under section 352.91  
 163.12 or the general state employees retirement plan of the Minnesota State Retirement System  
 163.13 as defined in section 352.021;

163.14 (3) while employed under clause (1), was assaulted by:

163.15 ~~an inmate at a state institution under control of the commissioner of the Department~~  
 163.16 ~~of Corrections~~ (i) a person under correctional supervision for a criminal offense; or

163.17 (ii) a client or patient at the Minnesota sex offender program, or at a state-operated  
 163.18 forensic services program as defined in section 352.91, subdivision 3j, under the control of  
 163.19 the commissioner of the Department of Human Services; and

163.20 ~~(3)~~ (4) as a direct result of the assault under clause (3), was determined to be  
 163.21 totally and permanently physically disabled under laws governing the Minnesota State  
 163.22 Retirement System.

163.23 (b) For a person to whom this section applies, the commissioner of the Department  
 163.24 of Corrections or the commissioner of the Department of Human Services must continue  
 163.25 to make the employer contribution for ~~hospital~~, medical, and dental benefits under the  
 163.26 State Employee Group Insurance Program after the person terminates state service. If  
 163.27 the person had dependent coverage at the time of terminating state service, employer  
 163.28 contributions for dependent coverage also must continue under this section. The employer  
 163.29 contributions must be in the amount of the employer contribution for active state  
 163.30 employees at the time each payment is made. The employer contributions must continue  
 163.31 until the person reaches age 65, provided the person makes the required employee  
 163.32 contributions, in the amount required of an active state employee, at the time and in  
 163.33 the manner specified by the commissioner.

164.1 **EFFECTIVE DATE.** This section is effective the day following final enactment  
 164.2 and applies to a person assaulted by an inmate, client, or patient on or after that date.

164.3 Sec. 2. Minnesota Statutes 2014, section 246.54, subdivision 1, is amended to read:

164.4 Subdivision 1. **County portion for cost of care.** (a) Except for chemical  
 164.5 dependency services provided under sections 254B.01 to 254B.09, the client's county  
 164.6 shall pay to the state of Minnesota a portion of the cost of care provided in a regional  
 164.7 treatment center or a state nursing facility to a client legally settled in that county. A  
 164.8 county's payment shall be made from the county's own sources of revenue and payments  
 164.9 shall equal a percentage of the cost of care, as determined by the commissioner, for each  
 164.10 day, or the portion thereof, that the client spends at a regional treatment center or a state  
 164.11 nursing facility according to the following schedule:

164.12 (1) zero percent for the first 30 days;

164.13 (2) 20 percent for days 31 ~~to 60~~ and over if the stay is determined to be clinically  
 164.14 appropriate for the client; and

164.15 (3) ~~75 percent for any days over 60~~ 100 percent for each day during the stay,  
 164.16 including the day of admission, when the facility determines that it is clinically appropriate  
 164.17 for the client to be discharged.

164.18 ~~(b) The increase in the county portion for cost of care under paragraph (a), clause~~  
 164.19 ~~(3), shall be imposed when the treatment facility has determined that it is clinically~~  
 164.20 ~~appropriate for the client to be discharged.~~

164.21 ~~(e)~~ (b) If payments received by the state under sections 246.50 to 246.53 exceed  
 164.22 80 percent of the cost of care for days over 31 to 60, or 25 percent for days over 60 for  
 164.23 clients who meet the criteria in paragraph (a), clause (2), the county shall be responsible  
 164.24 for paying the state only the remaining amount. The county shall not be entitled to  
 164.25 reimbursement from the client, the client's estate, or from the client's relatives, except as  
 164.26 provided in section 246.53.

164.27 Sec. 3. Minnesota Statutes 2014, section 246B.01, subdivision 2b, is amended to read:

164.28 Subd. 2b. **Cost of care.** "Cost of care" means the commissioner's charge for housing  
 164.29 ~~and~~ treatment, aftercare services, and supervision, provided to any person admitted to the  
 164.30 Minnesota sex offender program.

164.31 For purposes of this subdivision, "charge for housing ~~and~~ treatment, aftercare  
 164.32 services, and supervision" means the cost of services, treatment, maintenance, bonds issued  
 164.33 for capital improvements, depreciation of buildings and equipment, and indirect costs

165.1 related to the operation of state facilities. The commissioner may determine the charge for  
165.2 services on an anticipated average per diem basis as an all-inclusive charge per facility.

165.3       Sec. 4. **[246B.033] BIENNIAL EVALUATIONS OF CIVILLY COMMITTED**  
165.4 **SEX OFFENDERS.**

165.5       Subdivision 1. **Duty of executive director.** The executive director shall ensure that  
165.6 each civilly committed sex offender, including those on provisional discharge status, is  
165.7 evaluated in the form of a forensic risk assessment and treatment progress report not less  
165.8 than once every two years. The purpose of these evaluations is to identify the current  
165.9 treatment needs, risk of reoffense, and potential for reduction in custody. The executive  
165.10 director shall ensure that those performing such evaluations are qualified to do so and are  
165.11 trained on current research and legal standards relating to risk assessment, sex offender  
165.12 treatment, and reductions in custody.

165.13       Subd. 2. **Assessment and report.** A copy of the forensic risk assessment and the  
165.14 treatment progress report must be provided to the civilly committed sex offender and  
165.15 the civilly committed sex offender's attorney, along with a copy of a blank petition for  
165.16 reduction in custody and instructions on completing and filing the petition.

165.17       Subd. 3. **Suspension of duty if individual is in correctional facility.** The executive  
165.18 director may suspend or delay a civilly committed sex offender's evaluation during any  
165.19 time period that the individual is residing in a correctional facility operated by the state  
165.20 or federal government until the individual returns to the custody of the Minnesota sex  
165.21 offender program.

165.22       Subd. 4. **Right to petition.** This section must not impair or restrict a civilly  
165.23 committed sex offender's right to petition for a reduction in custody as provided in chapter  
165.24 253D. The executive director may adjust the scheduling of an individual's evaluation  
165.25 under this section to avoid duplication and inefficiency in circumstances where an  
165.26 individual has within a two-year period already received a risk assessment and treatment  
165.27 progress report as the result of a petition for reduction in custody.

165.28       **EFFECTIVE DATE.** This section is effective July 1, 2015. The executive director  
165.29 is not required to begin providing civilly committed sex offenders with evaluations until  
165.30 January 4, 2016.

165.31       Sec. 5. Minnesota Statutes 2014, section 246B.10, is amended to read:

165.32       **246B.10 LIABILITY OF COUNTY; REIMBURSEMENT.**

166.1 The civilly committed sex offender's county shall pay to the state a portion of the  
 166.2 cost of care provided in the Minnesota sex offender program to a civilly committed sex  
 166.3 offender who has legally settled in that county. A county's payment must be made from  
 166.4 the county's own sources of revenue and payments must equal 25 percent of the cost of  
 166.5 care, as determined by the commissioner, for each day or portion of a day, that the civilly  
 166.6 committed sex offender ~~spends at the facility~~ receives services, either within a Minnesota  
 166.7 sex offender program facility or while on provisional discharge. If payments received by  
 166.8 the state under this chapter exceed 75 percent of the cost of care for civilly committed sex  
 166.9 offenders admitted to the program on or after August 1, 2011, the county is responsible  
 166.10 for paying the state the remaining amount. If payments received by the state under this  
 166.11 chapter exceed 90 percent of the cost of care for civilly committed sex offenders admitted  
 166.12 to the program prior to August 1, 2011, the county is responsible for paying the state the  
 166.13 remaining amount. The county is not entitled to reimbursement from the civilly committed  
 166.14 sex offender, the civilly committed sex offender's estate, or from the civilly committed sex  
 166.15 offender's relatives, except as provided in section 246B.07.

166.16 **EFFECTIVE DATE.** The amendment to the provision governing county payments  
 166.17 for each day or portion of a day that a civilly committed sex offender receives services  
 166.18 is effective for civilly committed sex offenders provisionally discharged on or after the  
 166.19 day following final enactment.

## 166.20 ARTICLE 5

### 166.21 SIMPLIFICATION OF PUBLIC ASSISTANCE PROGRAMS

166.22 Section 1. Minnesota Statutes 2014, section 119B.011, subdivision 15, is amended to  
 166.23 read:

166.24 Subd. 15. **Income.** "Income" means earned ~~or unearned~~ income received by all  
 166.25 ~~family members, including~~ as defined under section 256P.01, subdivision 3, unearned  
 166.26 income as defined under section 256P.01, subdivision 8, and public assistance cash benefits  
 166.27 ~~and, including the Minnesota family investment program, diversionary work program,~~  
 166.28 work benefit, Minnesota supplemental aid, general assistance, refugee cash assistance,  
 166.29 at-home infant child care subsidy payments, unless specifically excluded and child support  
 166.30 and maintenance distributed to the family under section 256.741, subdivision 15. The  
 166.31 following are excluded deducted from income: funds used to pay for health insurance  
 166.32 premiums for family members, ~~Supplemental Security Income, scholarships, work-study~~  
 166.33 ~~income, and grants that cover costs or reimbursement for tuition, fees, books, and~~  
 166.34 ~~educational supplies; student loans for tuition, fees, books, supplies, and living expenses;~~

167.1 ~~state and federal earned income tax credits; assistance specifically excluded as income by~~  
 167.2 ~~law; in-kind income such as food support, energy assistance, foster care assistance, medical~~  
 167.3 ~~assistance, child care assistance, and housing subsidies; earned income of full-time or~~  
 167.4 ~~part-time students up to the age of 19, who have not earned a high school diploma or GED~~  
 167.5 ~~high school equivalency diploma including earnings from summer employment; grant~~  
 167.6 ~~awards under the family subsidy program; nonrecurring lump-sum income only to the~~  
 167.7 ~~extent that it is earmarked and used for the purpose for which it is paid; and any income~~  
 167.8 ~~assigned to the public authority according to section 256.741 and child or spousal support~~  
 167.9 ~~paid to or on behalf of a person or persons who live outside of the household. Income~~  
 167.10 ~~sources not included in this subdivision and section 256P.06, subdivision 3, are not counted.~~

167.11 Sec. 2. Minnesota Statutes 2014, section 119B.025, subdivision 1, is amended to read:

167.12 Subdivision 1. **Factors which must be verified.** (a) The county shall verify the  
 167.13 following at all initial child care applications using the universal application:

167.14 (1) identity of adults;

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

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

167.18 (4) age;

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

167.20 (6) Social Security number, if given;

167.21 (7) income;

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

167.24 (9) residence; and

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

167.26 (b) If a family did not use the universal application or child care addendum to apply  
 167.27 for child care assistance, the family must complete the universal application or child care  
 167.28 addendum at its next eligibility redetermination and the county must verify the factors  
 167.29 listed in paragraph (a) as part of that redetermination. Once a family has completed a  
 167.30 universal application or child care addendum, the county shall use the redetermination  
 167.31 form described in paragraph (c) for that family's subsequent redeterminations. Eligibility  
 167.32 must be redetermined at least every six months. A family is considered to have met the  
 167.33 eligibility redetermination requirement if a complete redetermination form and all required  
 167.34 verifications are received within 30 days after the date the form was due. Assistance shall  
 167.35 be payable retroactively from the redetermination due date. For a family where at least

168.1 one parent is under the age of 21, does not have a high school or general equivalency  
 168.2 diploma, and is a student in a school district or another similar program that provides or  
 168.3 arranges for child care, as well as parenting, social services, career and employment  
 168.4 supports, and academic support to achieve high school graduation, the redetermination of  
 168.5 eligibility shall be deferred beyond six months, but not to exceed 12 months, to the end of  
 168.6 the student's school year. If a family reports a change in an eligibility factor before the  
 168.7 family's next regularly scheduled redetermination, the county must recalculate eligibility  
 168.8 without requiring verification of any eligibility factor that did not change. Changes must  
 168.9 be reported as required by section 256P.07. A change in income occurs on the day the  
 168.10 participant received the first payment reflecting the change in income.

168.11 (c) The commissioner shall develop a redetermination form to redetermine eligibility  
 168.12 and a change report form to report changes that minimize paperwork for the county and  
 168.13 the participant.

168.14 Sec. 3. Minnesota Statutes 2014, section 119B.035, subdivision 4, is amended to read:

168.15 Subd. 4. **Assistance.** (a) A family is limited to a lifetime total of 12 months of  
 168.16 assistance under subdivision 2. The maximum rate of assistance is equal to 68 percent  
 168.17 of the rate established under section 119B.13 for care of infants in licensed family child  
 168.18 care in the applicant's county of residence.

168.19 (b) A participating family must report income and other family changes as specified in  
 168.20 sections 256P.06 and 256P.07, and the county's plan under section 119B.08, subdivision 3.

168.21 (c) Persons who are admitted to the at-home infant child care program retain their  
 168.22 position in any basic sliding fee program. Persons leaving the at-home infant child care  
 168.23 program reenter the basic sliding fee program at the position they would have occupied.

168.24 (d) Assistance under this section does not establish an employer-employee  
 168.25 relationship between any member of the assisted family and the county or state.

168.26 Sec. 4. Minnesota Statutes 2014, section 119B.09, subdivision 4, is amended to read:

168.27 Subd. 4. **Eligibility; annual income; calculation.** Annual income of the applicant  
 168.28 family is the current monthly income of the family multiplied by 12 or the income for  
 168.29 the 12-month period immediately preceding the date of application, or income calculated  
 168.30 by the method which provides the most accurate assessment of income available to the  
 168.31 family. Self-employment income must be calculated based on gross receipts less operating  
 168.32 expenses. Income must be recalculated when the family's income changes, but no less  
 168.33 often than every six months. For a family where at least one parent is under the age of  
 168.34 21, does not have a high school or general equivalency diploma, and is a student in a



169.1 school district or another similar program that provides or arranges for child care, as well  
169.2 as parenting, social services, career and employment supports, and academic support to  
169.3 achieve high school graduation, income must be recalculated when the family's income  
169.4 changes, but otherwise shall be deferred beyond six months, but not to exceed 12 months,  
169.5 to the end of the student's school year. Included lump sums counted as income under  
169.6 section 256P.06, subdivision 3, are to be annualized over 12 months. Income must be  
169.7 verified with documentary evidence. If the applicant does not have sufficient evidence of  
169.8 income, verification must be obtained from the source of the income.

169.9 Sec. 5. Minnesota Statutes 2014, section 256D.01, subdivision 1a, is amended to read:

169.10 Subd. 1a. **Standards.** (a) A principal objective in providing general assistance is  
169.11 to provide for single adults, childless couples, or children as defined in section 256D.02,  
169.12 subdivision 6, ineligible for federal programs who are unable to provide for themselves.  
169.13 The minimum standard of assistance determines the total amount of the general assistance  
169.14 grant without separate standards for shelter, utilities, or other needs.

169.15 (b) The commissioner shall set the standard of assistance for an assistance unit  
169.16 consisting of an adult recipient who is childless and unmarried or living apart from  
169.17 children and spouse and who does not live with a parent or parents or a legal custodian.  
169.18 When the other standards specified in this subdivision increase, this standard must also be  
169.19 increased by the same percentage.

169.20 (c) For an assistance unit consisting of a single adult who lives with a parent or  
169.21 parents, the general assistance standard of assistance is the amount that the aid to families  
169.22 with dependent children standard of assistance, in effect on July 16, 1996, would increase  
169.23 if the recipient were added as an additional minor child to an assistance unit consisting  
169.24 of the recipient's parent and all of that parent's family members, except that the standard  
169.25 may not exceed the standard for a general assistance recipient living alone. Benefits  
169.26 received by a responsible relative of the assistance unit under the Supplemental Security  
169.27 Income program, a workers' compensation program, the Minnesota supplemental aid  
169.28 program, or any other program based on the responsible relative's disability, and any  
169.29 benefits received by a responsible relative of the assistance unit under the Social Security  
169.30 retirement program, may not be counted in the determination of eligibility or benefit  
169.31 level for the assistance unit. Except as provided below, the assistance unit is ineligible  
169.32 for general assistance if the available resources or the countable income of the assistance  
169.33 unit and the parent or parents with whom the assistance unit lives are such that a family  
169.34 consisting of the assistance unit's parent or parents, the parent or parents' other family  
169.35 members and the assistance unit as the only or additional minor child would be financially

170.1 ineligible for general assistance. For the purposes of calculating the countable income  
 170.2 of the assistance unit's parent or parents, the calculation methods, ~~income deductions,~~  
 170.3 ~~exclusions, and disregards used when calculating the countable income for a single adult~~  
 170.4 ~~or childless couple must be used~~ follow the provisions under section 256P.06.

170.5 (d) For an assistance unit consisting of a childless couple, the standards of assistance  
 170.6 are the same as the first and second adult standards of the aid to families with dependent  
 170.7 children program in effect on July 16, 1996. If one member of the couple is not included  
 170.8 in the general assistance grant, the standard of assistance for the other is the second adult  
 170.9 standard of the aid to families with dependent children program as of July 16, 1996.

170.10 Sec. 6. Minnesota Statutes 2014, section 256D.02, is amended by adding a subdivision  
 170.11 to read:

170.12 Subd. 1a. **Assistance unit.** "Assistance unit" means an individual or an eligible  
 170.13 married couple who live together who are applying for or receiving benefits under this  
 170.14 chapter.

170.15 Sec. 7. Minnesota Statutes 2014, section 256D.02, is amended by adding a subdivision  
 170.16 to read:

170.17 Subd. 1b. **Cash assistance benefit.** "Cash assistance benefit" means any payment  
 170.18 received as a disability benefit, including veteran's or workers' compensation; old age,  
 170.19 survivors, and disability insurance; railroad retirement benefits; unemployment benefits;  
 170.20 and benefits under any federally aided categorical assistance program, Supplemental  
 170.21 Security Income, or other assistance program.

170.22 Sec. 8. Minnesota Statutes 2014, section 256D.02, subdivision 8, is amended to read:

170.23 Subd. 8. **Income.** "Income" means any form of income, including remuneration  
 170.24 for services performed as an employee and earned income from rental income and  
 170.25 self-employment earnings as described under section 256P.05 earned income as defined  
 170.26 under section 256P.01, subdivision 3, and unearned income as defined under section  
 170.27 256P.01, subdivision 8.

170.28 ~~Income includes any payments received as an annuity, retirement, or disability~~  
 170.29 ~~benefit, including veteran's or workers' compensation; old age, survivors, and disability~~  
 170.30 ~~insurance; railroad retirement benefits; unemployment benefits; and benefits under any~~  
 170.31 ~~federally aided categorical assistance program, supplementary security income, or other~~  
 170.32 ~~assistance program; rents, dividends, interest and royalties; and support and maintenance~~  
 170.33 ~~payments. Such payments may not be considered as available to meet the needs of any~~

171.1 ~~person other than the person for whose benefit they are received, unless that person is~~  
171.2 ~~a family member or a spouse and the income is not excluded under section 256D.01,~~  
171.3 ~~subdivision 1a. Goods and services provided in lieu of cash payment shall be excluded~~  
171.4 ~~from the definition of income, except that payments made for room, board, tuition or~~  
171.5 ~~fees by a parent, on behalf of a child enrolled as a full-time student in a postsecondary~~  
171.6 ~~institution, and payments made on behalf of an applicant or participant which the applicant~~  
171.7 ~~or participant could legally demand to receive personally in cash, must be included as~~  
171.8 ~~income. Benefits of an applicant or participant, such as those administered by the Social~~  
171.9 ~~Security Administration, that are paid to a representative payee, and are spent on behalf of~~  
171.10 ~~the applicant or participant, are considered available income of the applicant or participant.~~

171.11 Sec. 9. Minnesota Statutes 2014, section 256D.06, subdivision 1, is amended to read:

171.12 Subdivision 1. **Eligibility; amount of assistance.** General assistance shall be  
171.13 granted in an amount that when added to the ~~nonexempt~~ countable income as determined  
171.14 to be actually available to the assistance unit under section 256P.06, the total amount  
171.15 equals the applicable standard of assistance for general assistance. In determining  
171.16 eligibility for and the amount of assistance for an individual or married couple, the agency  
171.17 shall apply the earned income disregard as determined in section 256P.03.

171.18 Sec. 10. Minnesota Statutes 2014, section 256D.405, subdivision 3, is amended to read:

171.19 Subd. 3. **Reports.** Participants must report changes in circumstances according to  
171.20 section 256P.07 that affect eligibility or assistance payment amounts within ten days of the  
171.21 change. Participants who do not receive SSI because of excess income must complete a  
171.22 monthly report form if they have earned income, if they have income deemed to them  
171.23 from a financially responsible relative with whom the participant resides, or if they have  
171.24 income deemed to them by a sponsor. If the report form is not received before the end of  
171.25 the month in which it is due, the county agency must terminate assistance. The termination  
171.26 shall be effective on the first day of the month following the month in which the report  
171.27 was due. If a complete report is received within the month the assistance was terminated,  
171.28 the assistance unit is considered to have continued its application for assistance, effective  
171.29 the first day of the month the assistance was terminated.

171.30 Sec. 11. Minnesota Statutes 2014, section 256I.03, is amended by adding a subdivision  
171.31 to read:

171.32 Subd. 1b. **Assistance unit.** "Assistance unit" means an individual who is applying  
171.33 for or receiving benefits under this chapter.

172.1 Sec. 12. Minnesota Statutes 2014, section 256I.03, subdivision 7, is amended to read:

172.2 Subd. 7. **Countable income.** "Countable income" means all income received by an  
172.3 applicant or recipient as described under section 256P.06, less any applicable exclusions  
172.4 or disregards. For a recipient of any cash benefit from the SSI program, countable income  
172.5 means the SSI benefit limit in effect at the time the person is in a GRH, less the medical  
172.6 assistance personal needs allowance. If the SSI limit has been reduced for a person due to  
172.7 events occurring prior to the persons entering the GRH setting, countable income means  
172.8 actual income less any applicable exclusions and disregards.

172.9 Sec. 13. Minnesota Statutes 2014, section 256I.04, subdivision 1, is amended to read:

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

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

172.23 (b) The individual meets a category of eligibility under section 256D.05, subdivision  
172.24 1, paragraph (a), and the individual's resources are less than the standards specified by  
172.25 section 256P.02, and the individual's countable income as determined under ~~sections~~  
172.26 ~~256D.01 to 256D.21~~ section 256P.06, less the medical assistance personal needs allowance  
172.27 under section 256B.35 is less than the monthly rate specified in the agency's agreement  
172.28 with the provider of group residential housing in which the individual resides.

172.29 Sec. 14. Minnesota Statutes 2014, section 256I.06, subdivision 6, is amended to read:

172.30 Subd. 6. **Reports.** Recipients must report changes in circumstances according  
172.31 to section 256P.07 that affect eligibility or group residential housing payment amounts  
172.32 within ten days of the change. Recipients with countable earned income must complete  
172.33 a monthly household report form. If the report form is not received before the end of  
172.34 the month in which it is due, the county agency must terminate eligibility for group

173.1 residential housing payments. The termination shall be effective on the first day of the  
 173.2 month following the month in which the report was due. If a complete report is received  
 173.3 within the month eligibility was terminated, the individual is considered to have continued  
 173.4 an application for group residential housing payment effective the first day of the month  
 173.5 the eligibility was terminated.

173.6 Sec. 15. Minnesota Statutes 2014, section 256J.08, subdivision 26, is amended to read:

173.7 Subd. 26. **Earned income.** "Earned income" means ~~cash or in-kind income earned~~  
 173.8 ~~through the receipt of wages, salary, commissions, profit from employment activities, net~~  
 173.9 ~~profit from self-employment activities, payments made by an employer for regularly~~  
 173.10 ~~accrued vacation or sick leave, and any other profit from activity earned through effort or~~  
 173.11 ~~labor. The income must be in return for, or as a result of, legal activity~~ has the meaning  
 173.12 given in section 256P.01, subdivision 3.

173.13 Sec. 16. Minnesota Statutes 2014, section 256J.08, subdivision 86, is amended to read:

173.14 Subd. 86. **Unearned income.** "Unearned income" means ~~income received by~~  
 173.15 ~~a person that does not meet the definition of earned income. Unearned income includes~~  
 173.16 ~~income from a contract for deed, interest, dividends, unemployment benefits, disability~~  
 173.17 ~~insurance payments, veterans benefits, pension payments, return on capital investment,~~  
 173.18 ~~insurance payments or settlements, severance payments, child support and maintenance~~  
 173.19 ~~payments, and payments for illness or disability whether the premium payments are~~  
 173.20 ~~made in whole or in part by an employer or participant~~ has the meaning given in section  
 173.21 256P.01, subdivision 8.

173.22 Sec. 17. Minnesota Statutes 2014, section 256J.30, subdivision 1, is amended to read:

173.23 Subdivision 1. **Applicant reporting requirements.** An applicant must provide  
 173.24 information on an application form and supplemental forms about the applicant's  
 173.25 ~~circumstances which affect MFIP eligibility or the assistance payment. An applicant must~~  
 173.26 ~~report changes identified in subdivision 9 while the application is pending. When an~~  
 173.27 ~~applicant does not accurately report information on an application, both an overpayment~~  
 173.28 ~~and a referral for a fraud investigation may result. When an applicant does not provide~~  
 173.29 ~~information or documentation, the receipt of the assistance payment may be delayed or the~~  
 173.30 ~~application may be denied depending on the type of information required and its effect on~~  
 173.31 ~~eligibility~~ according to section 256P.07.

173.32 Sec. 18. Minnesota Statutes 2014, section 256J.30, subdivision 9, is amended to read:

174.1 Subd. 9. **Changes that must be reported.** A caregiver must report ~~the changes or~~  
 174.2 ~~anticipated changes specified in clauses (1) to (15) within ten days of the date they occur,~~  
 174.3 ~~at the time of the periodic recertification of eligibility under section 256P.04, subdivisions~~  
 174.4 ~~8 and 9, or within eight calendar days of a reporting period as in subdivision 5, whichever~~  
 174.5 ~~occurs first. A caregiver must report other changes at the time of the periodic recertification~~  
 174.6 ~~of eligibility under section 256P.04, subdivisions 8 and 9, or at the end of a reporting period~~  
 174.7 ~~under subdivision 5, as applicable. A caregiver must make these reports in writing to the~~  
 174.8 ~~agency. When an agency could have reduced or terminated assistance for one or more~~  
 174.9 ~~payment months if a delay in reporting a change specified under clauses (1) to (14) had~~  
 174.10 ~~not occurred, the agency must determine whether a timely notice under section 256J.31,~~  
 174.11 ~~subdivision 4, could have been issued on the day that the change occurred. When a timely~~  
 174.12 ~~notice could have been issued, each month's overpayment subsequent to that notice must be~~  
 174.13 ~~considered a client error overpayment under section 256J.38. Calculation of overpayments~~  
 174.14 ~~for late reporting under clause (15) is specified in section 256J.09, subdivision 9. Changes~~  
 174.15 ~~in circumstances which must be reported within ten days must also be reported on the~~  
 174.16 ~~MFIP household report form for the reporting period in which those changes occurred.~~  
 174.17 ~~Within ten days, a caregiver must report:~~ changes as specified under section 256P.07.  
 174.18 (1) a change in initial employment;  
 174.19 (2) a change in initial receipt of unearned income;  
 174.20 (3) a recurring change in unearned income;  
 174.21 (4) a nonrecurring change of unearned income that exceeds \$30;  
 174.22 (5) the receipt of a lump sum;  
 174.23 (6) an increase in assets that may cause the assistance unit to exceed asset limits;  
 174.24 (7) a change in the physical or mental status of an incapacitated member of the  
 174.25 assistance unit if the physical or mental status is the basis for reducing the hourly  
 174.26 participation requirements under section 256J.55, subdivision 1, or the type of activities  
 174.27 included in an employment plan under section 256J.521, subdivision 2;  
 174.28 (8) a change in employment status;  
 174.29 (9) the marriage or divorce of an assistance unit member;  
 174.30 (10) the death of a parent, minor child, or financially responsible person;  
 174.31 (11) a change in address or living quarters of the assistance unit;  
 174.32 (12) the sale, purchase, or other transfer of property;  
 174.33 (13) a change in school attendance of a caregiver under age 20 or an employed child;  
 174.34 (14) filing a lawsuit, a workers' compensation claim, or a monetary claim against a  
 174.35 third party; and

175.1 ~~(15) a change in household composition, including births, returns to and departures~~  
 175.2 ~~from the home of assistance unit members and financially responsible persons, or a change~~  
 175.3 ~~in the custody of a minor child.~~

175.4 Sec. 19. Minnesota Statutes 2014, section 256J.35, is amended to read:

175.5 **256J.35 AMOUNT OF ASSISTANCE PAYMENT.**

175.6 Except as provided in paragraphs (a) to (d), the amount of an assistance payment is  
 175.7 equal to the difference between the MFIP standard of need or the Minnesota family wage  
 175.8 level in section 256J.24 and countable income.

175.9 (a) Beginning July 1, 2015, MFIP assistance units are eligible for an MFIP housing  
 175.10 assistance grant of \$110 per month, unless:

175.11 (1) the housing assistance unit is currently receiving public and assisted rental  
 175.12 subsidies provided through the Department of Housing and Urban Development (HUD)  
 175.13 and is subject to section 256J.37, subdivision 3a; or

175.14 (2) the assistance unit is a child-only case under section 256J.88.

175.15 (b) When MFIP eligibility exists for the month of application, the amount of the  
 175.16 assistance payment for the month of application must be prorated from the date of  
 175.17 application or the date all other eligibility factors are met for that applicant, whichever is  
 175.18 later. This provision applies when an applicant loses at least one day of MFIP eligibility.

175.19 (c) MFIP overpayments to an assistance unit must be recouped according to section  
 175.20 ~~256J.38, subdivision 4~~ 256P.08, subdivision 5.

175.21 (d) An initial assistance payment must not be made to an applicant who is not  
 175.22 eligible on the date payment is made.

175.23 Sec. 20. Minnesota Statutes 2014, section 256J.40, is amended to read:

175.24 **256J.40 FAIR HEARINGS.**

175.25 Caregivers receiving a notice of intent to sanction or a notice of adverse action that  
 175.26 includes a sanction, reduction in benefits, suspension of benefits, denial of benefits, or  
 175.27 termination of benefits may request a fair hearing. A request for a fair hearing must be  
 175.28 submitted in writing to the county agency or to the commissioner and must be mailed  
 175.29 within 30 days after a participant or former participant receives written notice of the  
 175.30 agency's action or within 90 days when a participant or former participant shows good  
 175.31 cause for not submitting the request within 30 days. A former participant who receives a  
 175.32 notice of adverse action due to an overpayment may appeal the adverse action according  
 175.33 to the requirements in this section. Issues that may be appealed are:

175.34 (1) the amount of the assistance payment;

- 176.1 (2) a suspension, reduction, denial, or termination of assistance;
- 176.2 (3) the basis for an overpayment, the calculated amount of an overpayment, and
- 176.3 the level of recoupment;
- 176.4 (4) the eligibility for an assistance payment; and
- 176.5 (5) the use of protective or vendor payments under section 256J.39, subdivision 2,
- 176.6 clauses (1) to (3).

176.7 Except for benefits issued under section 256J.95, a county agency must not reduce,

176.8 suspend, or terminate payment when an aggrieved participant requests a fair hearing

176.9 prior to the effective date of the adverse action or within ten days of the mailing of the

176.10 notice of adverse action, whichever is later, unless the participant requests in writing not

176.11 to receive continued assistance pending a hearing decision. An appeal request cannot

176.12 extend benefits for the diversionary work program under section 256J.95 beyond the

176.13 four-month time limit. Assistance issued pending a fair hearing is subject to recovery

176.14 under section ~~256J.38~~ 256P.08 when as a result of the fair hearing decision the participant

176.15 is determined ineligible for assistance or the amount of the assistance received. A county

176.16 agency may increase or reduce an assistance payment while an appeal is pending when the

176.17 circumstances of the participant change and are not related to the issue on appeal. The

176.18 commissioner's order is binding on a county agency. No additional notice is required to

176.19 enforce the commissioner's order.

176.20 A county agency shall reimburse appellants for reasonable and necessary expenses

176.21 of attendance at the hearing, such as child care and transportation costs and for the

176.22 transportation expenses of the appellant's witnesses and representatives to and from the

176.23 hearing. Reasonable and necessary expenses do not include legal fees. Fair hearings

176.24 must be conducted at a reasonable time and date by an impartial human services judge

176.25 employed by the department. The hearing may be conducted by telephone or at a site that

176.26 is readily accessible to persons with disabilities.

176.27 The appellant may introduce new or additional evidence relevant to the issues on

176.28 appeal. Recommendations of the human services judge and decisions of the commissioner

176.29 must be based on evidence in the hearing record and are not limited to a review of the

176.30 county agency action.

176.31 Sec. 21. Minnesota Statutes 2014, section 256J.95, subdivision 19, is amended to read:

176.32 Subd. 19. **DWP overpayments and underpayments.** DWP benefits are subject

176.33 to overpayments and underpayments. Anytime an overpayment or an underpayment is

176.34 determined for DWP, the correction shall be calculated using prospective budgeting.

176.35 Corrections shall be determined based on the policy in section 256J.34, subdivision 1,



177.1 paragraphs (a), (b), and (c). ATM errors must be recovered as specified in section ~~256J.38,~~  
177.2 ~~subdivision 5~~ 256P.08, subdivision 6. Cross program recoupment of overpayments cannot  
177.3 be assigned to or from DWP.

177.4 Sec. 22. Minnesota Statutes 2014, section 256P.001, is amended to read:

177.5 **256P.001 APPLICABILITY.**

177.6 General assistance and Minnesota supplemental aid under chapter 256D, child care  
177.7 assistance programs under chapter 119B, and programs governed by chapter 256I or 256J  
177.8 are subject to the requirements of this chapter, unless otherwise specified or exempted.

177.9 Sec. 23. Minnesota Statutes 2014, section 256P.01, is amended by adding a subdivision  
177.10 to read:

177.11 Subd. 2a. **Assistance unit.** "Assistance unit" is defined by program area under  
177.12 sections 119B.011, subdivision 13; 256D.02, subdivision 1a; 256D.35, subdivision 3a;  
177.13 256I.03, subdivision 1b; and 256J.08, subdivision 7.

177.14 Sec. 24. Minnesota Statutes 2014, section 256P.01, subdivision 3, is amended to read:

177.15 Subd. 3. **Earned income.** "Earned income" means cash or in-kind income earned  
177.16 through the receipt of wages, salary, commissions, ~~bonuses, tips, gratuities,~~ profit from  
177.17 employment activities, net profit from self-employment activities, payments made by  
177.18 an employer for regularly accrued vacation or sick leave, ~~and any~~ severance pay based  
177.19 on accrued leave time, payments from training programs at a rate at or greater than the  
177.20 state's minimum wage, royalties, honoraria, or other profit from activity ~~earned through~~  
177.21 effort that results from the client's work, service, effort, or labor. The income must be in  
177.22 return for, or as a result of, legal activity.

177.23 Sec. 25. Minnesota Statutes 2014, section 256P.01, is amended by adding a subdivision  
177.24 to read:

177.25 Subd. 8. **Unearned income.** "Unearned income" has the meaning given in section  
177.26 256P.06, subdivision 3, clause (2).

177.27 Sec. 26. Minnesota Statutes 2014, section 256P.02, is amended by adding a subdivision  
177.28 to read:

177.29 Subd. 1a. **Exemption.** Participants who qualify for child care assistance programs  
177.30 under chapter 119B are exempt from this section.

178.1 Sec. 27. Minnesota Statutes 2014, section 256P.03, subdivision 1, is amended to read:

178.2 Subdivision 1. **Exempted programs.** Participants who qualify for child care  
178.3 assistance programs under chapter 119B, Minnesota supplemental aid under chapter  
178.4 256D<sub>2</sub> and for group residential housing under chapter 256I on the basis of eligibility for  
178.5 Supplemental Security Income are exempt from this section.

178.6 Sec. 28. Minnesota Statutes 2014, section 256P.04, subdivision 1, is amended to read:

178.7 Subdivision 1. **Exemption.** Participants who receive Minnesota supplemental aid  
178.8 and who maintain Supplemental Security Income eligibility under chapters 256D and 256I  
178.9 are exempt from the reporting requirements of this section, except that the policies and  
178.10 procedures for transfers of assets are those used by the medical assistance program under  
178.11 section 256B.0595. Participants who receive child care assistance under chapter 119B are  
178.12 exempt from the requirements of this section.

178.13 Sec. 29. Minnesota Statutes 2014, section 256P.04, subdivision 4, is amended to read:

178.14 Subd. 4. **Factors to be verified.** (a) The agency shall verify the following at  
178.15 application:

178.16 (1) identity of adults;

178.17 (2) age, if necessary to determine eligibility;

178.18 (3) immigration status;

178.19 (4) income;

178.20 (5) spousal support and child support payments made to persons outside the  
178.21 household;

178.22 (6) vehicles;

178.23 (7) checking and savings accounts;

178.24 (8) inconsistent information, if related to eligibility;

178.25 (9) residence; ~~and~~

178.26 (10) Social Security number; and

178.27 (11) use of nonrecurring income under section 256P.06, subdivision 3, clause (2),  
178.28 item (ix), for the intended purpose in which it was given and received.

178.29 (b) Applicants who are qualified noncitizens and victims of domestic violence as  
178.30 defined under section 256J.08, subdivision 73, clause (7), are not required to verify the  
178.31 information in paragraph (a), clause (10). When a Social Security number is not provided  
178.32 to the agency for verification, this requirement is satisfied when each member of the  
178.33 assistance unit cooperates with the procedures for verification of Social Security numbers,

179.1 issuance of duplicate cards, and issuance of new numbers which have been established  
 179.2 jointly between the Social Security Administration and the commissioner.

179.3 Sec. 30. Minnesota Statutes 2014, section 256P.05, subdivision 1, is amended to read:

179.4 Subdivision 1. **Exempted programs.** Participants who qualify for child care  
 179.5 assistance programs under chapter 119B, Minnesota supplemental aid under chapter  
 179.6 256D<sub>2</sub> and for group residential housing under chapter 256I on the basis of eligibility for  
 179.7 Supplemental Security Income are exempt from this section.

179.8 Sec. 31. **[256P.06] INCOME CALCULATIONS.**

179.9 Subdivision 1. **Reporting of income.** To determine eligibility, the county agency  
 179.10 must evaluate income received by members of the assistance unit, or by other persons  
 179.11 whose income is considered available to the assistance unit, and only count income that  
 179.12 is available to the assistance unit. Income is available if the individual has legal access  
 179.13 to the income.

179.14 Subd. 2. **Exempted individuals.** The following members of an assistance unit  
 179.15 under chapters 119B and 256J are exempt from having their earned income count towards  
 179.16 the income of an assistance unit:

- 179.17 (1) children under six years old;  
 179.18 (2) caregivers under 20 years of age enrolled at least half-time in school; and  
 179.19 (3) minors enrolled in school full time.

179.20 Subd. 3. **Income inclusions.** The following must be included in determining the  
 179.21 income of an assistance unit:

- 179.22 (1) earned income; and  
 179.23 (2) unearned income, which includes:  
 179.24 (i) interest and dividends from investments and savings;  
 179.25 (ii) capital gains as defined by the Internal Revenue Service from any sale of real  
 179.26 property;  
 179.27 (iii) proceeds from rent and contract for deed payments in excess of the principal  
 179.28 and interest portion owed on property;  
 179.29 (iv) income from trusts, excluding special needs and supplemental needs trusts;  
 179.30 (v) interest income from loans made by the participant or household;  
 179.31 (vi) cash prizes and winnings;  
 179.32 (vii) unemployment insurance income;  
 179.33 (viii) retirement, survivors, and disability insurance payments;

180.1 (ix) nonrecurring income over \$60 per quarter unless earmarked and used for the  
 180.2 purpose for which it is intended. Income and use of this income is subject to verification  
 180.3 requirements under section 256P.04;

180.4 (x) retirement benefits;

180.5 (xi) cash assistance benefits, as defined by each program in chapters 119B, 256D,  
 180.6 256I, and 256J;

180.7 (xii) tribal per capita payments unless excluded by federal and state law;

180.8 (xiii) income and payments from service and rehabilitation programs that meet  
 180.9 or exceed the state's minimum wage rate;

180.10 (xiv) income from members of the United States armed forces unless excluded from  
 180.11 income taxes according to federal or state law; and

180.12 (xv) child and spousal support.

180.13 **Sec. 32. [256P.07] REPORTING OF INCOME AND CHANGES.**

180.14 **Subdivision 1. Exempted programs.** Participants who qualify for Minnesota  
 180.15 supplemental aid under chapter 256D and for group residential housing under chapter 256I  
 180.16 on the basis of eligibility for Supplemental Security Income are exempt from this section.

180.17 **Subd. 2. Reporting requirements.** An applicant or participant must provide  
 180.18 information on an application and any subsequent reporting forms about the assistance  
 180.19 unit's circumstances that affect eligibility or benefits. An applicant or assistance unit must  
 180.20 report changes identified in subdivision 3. When information is not accurately reported,  
 180.21 both an overpayment and a referral for a fraud investigation may result. When information  
 180.22 or documentation is not provided, the receipt of any benefit may be delayed or denied,  
 180.23 depending on the type of information required and its effect on eligibility.

180.24 **Subd. 3. Changes that must be reported.** An assistance unit must report the  
 180.25 changes or anticipated changes specified in clauses (1) to (12) within ten days of the date  
 180.26 they occur, at the time of recertification of eligibility under section 256P.04, subdivisions  
 180.27 8 and 9, or within eight calendar days of a reporting period, whichever occurs first. An  
 180.28 assistance unit must report other changes at the time of recertification of eligibility under  
 180.29 section 256P.04, subdivisions 8 and 9, or at the end of a reporting period, as applicable.  
 180.30 When an agency could have reduced or terminated assistance for one or more payment  
 180.31 months if a delay in reporting a change specified under clauses (1) to (12) had not  
 180.32 occurred, the agency must determine whether a timely notice could have been issued  
 180.33 on the day that the change occurred. When a timely notice could have been issued,  
 180.34 each month's overpayment subsequent to that notice must be considered a client error  
 180.35 overpayment under section 119B.11, subdivision 2a; 256D.09, subdivision 6; 256D.49,

181.1 subdivision 3; 256J.38; or 256P.08. Changes in circumstances that must be reported within  
 181.2 ten days must also be reported for the reporting period in which those changes occurred.

181.3 Within ten days, an assistance unit must report a:

181.4 (1) change in earned income of \$100 per month or greater;

181.5 (2) change in unearned income of \$50 per month or greater;

181.6 (3) change in employment status and hours;

181.7 (4) change in address or residence;

181.8 (5) change in household composition with the exception of programs under chapter

181.9 256I;

181.10 (6) receipt of a lump-sum payment;

181.11 (7) increase in assets if over \$9,000 with the exception of programs under chapter

181.12 119B;

181.13 (8) change in citizenship or immigration status;

181.14 (9) change in family status with the exception of programs under chapter 256I;

181.15 (10) change in disability status of a unit member, with the exception of programs

181.16 under chapter 119B;

181.17 (11) new rent subsidy or a change in rent subsidy; and

181.18 (12) sale, purchase, or transfer of real property.

181.19 Subd. 4. **MFIP-specific reporting.** In addition to subdivision 3, an assistance unit  
 181.20 under chapter 256J, within ten days of the change, must report:

181.21 (1) a pregnancy not resulting in birth when there are no other minor children; and

181.22 (2) a change in school attendance of a parent under 20 years of age or of an

181.23 employed child.

181.24 Subd. 5. **DWP-specific reporting.** In addition to subdivisions 3 and 4, an assistance  
 181.25 unit participating in the diversionary work program under section 256J.95 must report

181.26 on an application:

181.27 (1) shelter expenses; and

181.28 (2) utility expenses.

181.29 Subd. 6. **Child care assistance programs-specific reporting.** In addition to

181.30 subdivision 3, an assistance unit under chapter 119B, within ten days of the change, must

181.31 report a:

181.32 (1) change in a parentally responsible individual's visitation schedule or custody  
 181.33 arrangement for any child receiving child care assistance program benefits; and

181.34 (2) change in authorized activity status.

182.1 Subd. 7. **MSA-specific reporting.** In addition to subdivision 3, an assistance  
182.2 unit participating in the Minnesota supplemental aid program under section 256D.44,  
182.3 subdivision 5, paragraph (f), within ten days of the change, must report shelter expenses.

182.4 Sec. 33. **[256P.08] CORRECTION OF OVERPAYMENTS AND**  
182.5 **UNDERPAYMENTS.**

182.6 Subdivision 1. **Exempted programs.** Participants who qualify for child care  
182.7 assistance programs under chapter 119B and group residential housing under chapter  
182.8 256I are exempt from this section.

182.9 Subd. 2. **Scope of overpayment.** (a) When a participant or former participant  
182.10 receives an overpayment due to agency, client, or ATM error, or due to assistance received  
182.11 while an appeal is pending and the participant or former participant is determined  
182.12 ineligible for assistance or for less assistance than was received, except as provided for  
182.13 interim assistance in section 256D.06, subdivision 5, the county agency must recoup or  
182.14 recover the overpayment using the following methods:

182.15 (1) reconstruct each affected budget month and corresponding payment month;  
182.16 (2) use the policies and procedures that were in effect for the payment month; and  
182.17 (3) do not allow employment disregards in the calculation of the overpayment when  
182.18 the unit has not reported within two calendar months following the end of the month in  
182.19 which the income was received.

182.20 (b) Establishment of an overpayment is limited to 12 months prior to the month of  
182.21 discovery due to agency error. Establishment of an overpayment is limited to six years  
182.22 prior to the month of discovery due to client error or an intentional program violation  
182.23 determined under section 256.046.

182.24 Subd. 3. **Notice of overpayment.** When a county agency discovers that a participant  
182.25 or former participant has received an overpayment for one or more months, the county  
182.26 agency must notify the participant or former participant of the overpayment in writing.  
182.27 A notice of overpayment must specify the reason for the overpayment, the authority for  
182.28 citing the overpayment, the time period in which the overpayment occurred, the amount of  
182.29 the overpayment, and the participant's or former participant's right to appeal. No limit  
182.30 applies to the period in which the county agency is required to recoup or recover an  
182.31 overpayment according to subdivisions 4 and 5.

182.32 Subd. 4. **Recovering MFIP overpayments.** A county agency must initiate efforts to  
182.33 recover overpayments paid to a former participant or caregiver. Caregivers, both parental  
182.34 and nonparental, and minor caregivers of an assistance unit at the time an overpayment  
182.35 occurs, whether receiving assistance or not, are jointly and individually liable for repayment

183.1 of the overpayment. The county agency must request repayment from the former  
183.2 participants and caregivers. When an agreement for repayment is not completed within six  
183.3 months of the date of discovery or when there is a default on an agreement for repayment  
183.4 after six months, the county agency must initiate recovery consistent with chapter 270A or  
183.5 section 541.05. When a person has been convicted of fraud under section 256.98, recovery  
183.6 must be sought regardless of the amount of overpayment. When an overpayment is less  
183.7 than \$35, and is not the result of a fraud conviction under section 256.98, the county agency  
183.8 must not seek recovery under this subdivision. The county agency must retain information  
183.9 about all overpayments regardless of the amount. When an adult, adult caregiver, or minor  
183.10 caregiver reapplies for assistance, the overpayment must be recouped under subdivision 5.

183.11 Subd. 4a. **Recovering general assistance and Minnesota supplemental aid**  
183.12 **overpayments.** (a) If an amount of assistance is paid to an assistance unit in excess of the  
183.13 payment due, the excess amount must be recovered by the agency. The agency shall give  
183.14 written notice to the recipient of its intention to recover the payment.

183.15 (b) If the person is no longer receiving assistance, the agency may request voluntary  
183.16 repayment or pursue civil recovery.

183.17 (c) If the person is receiving assistance, except as provided for interim assistance in  
183.18 section 256D.06, subdivision 5, when an overpayment occurs, the agency shall recover the  
183.19 overpayment by withholding an amount equal to:

183.20 (1) three percent of the assistance unit's standard of need for all Minnesota  
183.21 supplemental aid assistance units, and nonfraud cases for general assistance; and

183.22 (2) ten percent where fraud has occurred in general assistance cases; or

183.23 (3) the amount of the monthly general assistance or Minnesota supplemental aid  
183.24 payment, whichever is less.

183.25 (d) When there is both an overpayment and underpayment, the county agency shall  
183.26 offset one against the other in correcting the payment.

183.27 (e) Overpayments may also be voluntarily repaid in part or in full by the individual,  
183.28 in addition to the assistance reductions provided in this subdivision, to include further  
183.29 voluntary reductions in the grant level agreed to in writing by the individual, until the  
183.30 total amount of the overpayment is repaid.

183.31 (f) The county agency shall make reasonable efforts to recover overpayments from  
183.32 a person who no longer receives assistance. The agency is not required to attempt to  
183.33 recover overpayments of less than \$35 if the person is no longer on assistance and if the  
183.34 individual does not receive assistance again within three years, unless the individual has  
183.35 been convicted of violating section 256.98.

184.1 (g) Establishment of an overpayment is limited to 12 months prior to the month of  
184.2 discovery due to agency error, and six years prior to the month of discovery due to client  
184.3 error or an intentional program violation determined under section 256.046.

184.4 (h) Residents of licensed residential facilities shall not have overpayments recovered  
184.5 from their personal needs allowance.

184.6 Subd. 5. **Recouping overpayments from MFIP participants.** A participant may  
184.7 voluntarily repay, in part or in full, an overpayment even if assistance is reduced under this  
184.8 subdivision, until the total amount of the overpayment is repaid. When an overpayment  
184.9 occurs due to fraud, the county agency must recover from the overpaid assistance unit,  
184.10 including child-only cases, ten percent of the applicable standard or the amount of the  
184.11 monthly assistance payment, whichever is less. When a nonfraud overpayment occurs, the  
184.12 county agency must recover from the overpaid assistance unit, including child-only cases,  
184.13 three percent of the standard of need or the amount of the monthly assistance payment,  
184.14 whichever is less.

184.15 Subd. 6. **Recovering automatic teller machine errors.** For recipients receiving  
184.16 benefits by electronic benefit transfer, if the overpayment is a result of an ATM dispensing  
184.17 funds in error to the recipient, the agency may recover the ATM error by immediately  
184.18 withdrawing funds from the recipient's electronic benefit transfer account, up to the  
184.19 amount of the error.

184.20 Subd. 7. **Scope of underpayments.** A county agency must issue a corrective  
184.21 payment for underpayments made to a participant or to a person who would be a  
184.22 participant if an agency or client error causing the underpayment had not occurred.  
184.23 Corrective payments are limited to 12 months prior to the month of discovery. The county  
184.24 agency must issue the corrective payment according to subdivision 9.

184.25 Subd. 8. **Identifying the underpayment.** An underpayment may be identified by  
184.26 a county agency, participant, former participant, or person who would be a participant  
184.27 except for agency or client error.

184.28 Subd. 9. **Issuing corrective payments.** A county agency must correct an  
184.29 underpayment within seven calendar days after the underpayment has been identified,  
184.30 by adding the corrective payment amount to the monthly assistance payment of the  
184.31 participant, issuing a separate payment to a participant or former participant, or reducing  
184.32 an existing overpayment balance. When an underpayment occurs in a payment month  
184.33 and is not identified until the next payment month or later, the county agency must first  
184.34 subtract the underpayment from any overpayment balance before issuing the corrective  
184.35 payment. The county agency must not apply an underpayment in a current payment month  
184.36 against an overpayment balance. When an underpayment in the current payment month



185.1 is identified, the corrective payment must be issued within seven calendar days after the  
 185.2 underpayment is identified. Corrective payments must be excluded when determining the  
 185.3 applicant's or recipient's income and resources for the month of payment. The county  
 185.4 agency must correct underpayments using the following methods:

185.5 (1) reconstruct each affected budget month and corresponding payment month; and  
 185.6 (2) use the policies and procedures that were in effect for the payment month.

185.7 Subd. 10. **Appeals.** A participant may appeal an underpayment, an overpayment,  
 185.8 and a reduction in an assistance payment made to recoup the overpayment under  
 185.9 subdivisions 4a and 5. The participant's appeal of each issue must be timely under section  
 185.10 256.045. When an appeal based on the notice issued under subdivision 3 is not timely, the  
 185.11 fact or the amount of that overpayment must not be considered as a part of a later appeal,  
 185.12 including an appeal of a reduction in an assistance payment to recoup that overpayment.

185.13 Sec. 34. **REPEALER.**

185.14 (a) Minnesota Statutes 2014, sections 256D.0513; 256D.06, subdivision 8; 256D.09,  
 185.15 subdivision 6; 256D.49; and 256J.38, are repealed.

185.16 (b) Minnesota Rules, part 3400.0170, subparts 5, 6, 12, and 13, are repealed.

185.17 Sec. 35. **EFFECTIVE DATE.**

185.18 This article is effective August 1, 2016.

## 185.19 **ARTICLE 6**

### 185.20 **CONTINUING CARE**

185.21 Section 1. Minnesota Statutes 2014, section 13.461, is amended by adding a  
 185.22 subdivision to read:

185.23 Subd. 32. **ABLE accounts and designated beneficiaries.** Data on ABLE accounts  
 185.24 and designated beneficiaries of ABLE accounts are classified under section 256Q.05,  
 185.25 subdivision 7.

185.26 Sec. 2. Minnesota Statutes 2014, section 144.057, subdivision 1, is amended to read:

185.27 Subdivision 1. **Background studies required.** The commissioner of health shall  
 185.28 contract with the commissioner of human services to conduct background studies of:

185.29 (1) individuals providing services which have direct contact, as defined under  
 185.30 section 245C.02, subdivision 11, with patients and residents in hospitals, boarding care  
 185.31 homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing  
 185.32 homes and home care agencies licensed under chapter 144A; residential care homes

186.1 licensed under chapter 144B, and board and lodging establishments that are registered to  
 186.2 provide supportive or health supervision services under section 157.17;

186.3 (2) individuals specified in section 245C.03, subdivision 1, who perform direct  
 186.4 contact services in a nursing home or a home care agency licensed under chapter 144A  
 186.5 or a boarding care home licensed under sections 144.50 to 144.58, ~~and~~. If the individual  
 186.6 under study resides outside Minnesota, the study must ~~be at least as comprehensive as~~  
 186.7 ~~that of a Minnesota resident and include a search of information from the criminal justice~~  
 186.8 ~~data communications network in the state where the subject of the study resides~~ include a  
 186.9 check for substantiated findings of maltreatment of adults and children in the individual's  
 186.10 state of residence when the information is made available by that state, and must include a  
 186.11 check of the National Crime Information Center database;

186.12 (3) beginning July 1, 1999, all other employees in nursing homes licensed under  
 186.13 chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. A  
 186.14 disqualification of an individual in this section shall disqualify the individual from  
 186.15 positions allowing direct contact or access to patients or residents receiving services.  
 186.16 "Access" means physical access to a client or the client's personal property without  
 186.17 continuous, direct supervision as defined in section 245C.02, subdivision 8, when the  
 186.18 employee's employment responsibilities do not include providing direct contact services;

186.19 (4) individuals employed by a supplemental nursing services agency, as defined  
 186.20 under section 144A.70, who are providing services in health care facilities; and

186.21 (5) controlling persons of a supplemental nursing services agency, as defined under  
 186.22 section 144A.70.

186.23 If a facility or program is licensed by the Department of Human Services and  
 186.24 subject to the background study provisions of chapter 245C and is also licensed by the  
 186.25 Department of Health, the Department of Human Services is solely responsible for the  
 186.26 background studies of individuals in the jointly licensed programs.

186.27 Sec. 3. Minnesota Statutes 2014, section 245C.08, subdivision 1, is amended to read:

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

186.31 (1) information related to names of substantiated perpetrators of maltreatment of  
 186.32 vulnerable adults that has been received by the commissioner as required under section  
 186.33 626.557, subdivision 9c, paragraph (j);

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

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

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

187.9 (5) except as provided in clause (6), information from the national crime information  
187.10 system when the commissioner has reasonable cause as defined under section 245C.05,  
187.11 subdivision 5, or as required under section 144.057, subdivision 1, clause (2); and

187.12 (6) for a background study related to a child foster care application for licensure, a  
187.13 transfer of permanent legal and physical custody of a child under sections 260C.503 to  
187.14 260C.515, or adoptions, the commissioner shall also review:

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

187.17 (ii) information from national crime information databases, when the background  
187.18 study subject is 18 years of age or older.

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

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

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

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

188.1 Sec. 4. Minnesota Statutes 2014, section 245C.12, is amended to read:

188.2 **245C.12 BACKGROUND STUDY; TRIBAL ORGANIZATIONS.**

188.3 (a) For the purposes of background studies completed by tribal organizations  
188.4 performing licensing activities otherwise required of the commissioner under this chapter,  
188.5 after obtaining consent from the background study subject, tribal licensing agencies shall  
188.6 have access to criminal history data in the same manner as county licensing agencies and  
188.7 private licensing agencies under this chapter.

188.8 (b) Tribal organizations may contract with the commissioner to obtain background  
188.9 study data on individuals under tribal jurisdiction related to adoptions according to  
188.10 section 245C.34. Tribal organizations may also contract with the commissioner to obtain  
188.11 background study data on individuals under tribal jurisdiction related to child foster care  
188.12 according to section 245C.34.

188.13 (c) For the purposes of background studies completed to comply with a tribal  
188.14 organization's licensing requirements for individuals affiliated with a tribally licensed  
188.15 nursing facility, the commissioner shall obtain criminal history data from the National  
188.16 Criminal Records Repository in accordance with section 245C.32.

188.17 Sec. 5. Minnesota Statutes 2014, section 256.478, is amended to read:

188.18 **256.478 HOME AND COMMUNITY-BASED SERVICES TRANSITIONS**  
188.19 **GRANTS.**

188.20 (a) The commissioner shall make available home and community-based services  
188.21 transition grants to serve individuals who do not meet eligibility criteria for the medical  
188.22 assistance program under section 256B.056 or 256B.057, but who otherwise meet the  
188.23 criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24.

188.24 ~~(b) For the purposes of this section, the commissioner has the authority to transfer~~  
188.25 ~~funds between the medical assistance account and the home and community-based~~  
188.26 ~~services transitions grants account.~~

188.27 Sec. 6. Minnesota Statutes 2014, section 256.975, subdivision 8, is amended to read:

188.28 Subd. 8. ~~Promotion of~~ Establish long-term care insurance call center. Within  
188.29 the limits of appropriations specifically for this purpose, the Minnesota Board on Aging,  
188.30 ~~either directly or through contract,~~ its Senior LinkAge Line established under section  
188.31 256.975, subdivision 7, shall promote the provision of employer-sponsored, establish  
188.32 a long-term care call center that promotes planning for long-term care, and provides  
188.33 information about long-term care insurance, other long-term care financing options, and  
188.34 resources that support Minnesotans as they age or have more long-term chronic care

189.1 ~~needs. The board shall encourage private and public sector employers to make long-term~~  
 189.2 ~~care insurance available to employees, provide interested employers with information~~  
 189.3 ~~on the long-term care insurance product offered to state employees, and provide work~~  
 189.4 ~~with a variety of stakeholders, including employers, insurance providers, brokers, or~~  
 189.5 ~~other sellers of products and consumers to develop the call center. The board shall seek~~  
 189.6 ~~technical assistance to employers from the commissioner in designing long-term care~~  
 189.7 ~~insurance products and contacting companies offering long-term care insurance products~~  
 189.8 ~~for implementation of the call center.~~

189.9 Sec. 7. Minnesota Statutes 2014, section 256B.056, subdivision 5c, is amended to read:

189.10 Subd. 5c. **Excess income standard.** (a) The excess income standard for parents  
 189.11 and caretaker relatives, pregnant women, infants, and children ages two through 20 is the  
 189.12 standard specified in subdivision 4, paragraph (b).

189.13 (b) Prior to January 1, 2017, the excess income standard for a person whose  
 189.14 eligibility is based on blindness, disability, or age of 65 or more years shall equal 75  
 189.15 percent of the federal poverty guidelines.

189.16 (c) Between January 1, 2017, and December 31, 2018, the excess income standard  
 189.17 for a person whose eligibility is based on blindness, disability, or age of 65 or more years,  
 189.18 shall equal 85 percent of the federal poverty guidelines.

189.19 (d) Beginning January 1, 2019, the excess income standard for a person whose  
 189.20 eligibility is based on blindness, disability, or age of 65 or more years, shall equal 95  
 189.21 percent of the federal poverty guidelines.

189.22 **EFFECTIVE DATE.** This section is effective July 1, 2015.

189.23 Sec. 8. Minnesota Statutes 2014, section 256B.057, subdivision 9, is amended to read:

189.24 Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid  
 189.25 for a person who is employed and who:

189.26 (1) but for excess earnings or assets, meets the definition of disabled under the  
 189.27 Supplemental Security Income program;

189.28 (2) meets the asset limits in paragraph (d); and

189.29 (3) pays a premium and other obligations under paragraph (e).

189.30 (b) For purposes of eligibility, there is a \$65 earned income disregard. To be eligible  
 189.31 for medical assistance under this subdivision, a person must have more than \$65 of earned  
 189.32 income. Earned income must have Medicare, Social Security, and applicable state and  
 189.33 federal taxes withheld. The person must document earned income tax withholding. Any

190.1 spousal income or assets shall be disregarded for purposes of eligibility and premium  
190.2 determinations.

190.3 (c) After the month of enrollment, a person enrolled in medical assistance under  
190.4 this subdivision who:

190.5 (1) is temporarily unable to work and without receipt of earned income due to a  
190.6 medical condition, as verified by a physician; or

190.7 (2) loses employment for reasons not attributable to the enrollee, and is without  
190.8 receipt of earned income may retain eligibility for up to four consecutive months after the  
190.9 month of job loss. To receive a four-month extension, enrollees must verify the medical  
190.10 condition or provide notification of job loss. All other eligibility requirements must be met  
190.11 and the enrollee must pay all calculated premium costs for continued eligibility.

190.12 (d) For purposes of determining eligibility under this subdivision, a person's assets  
190.13 must not exceed \$20,000, excluding:

190.14 (1) all assets excluded under section 256B.056;

190.15 (2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans,  
190.16 Keogh plans, and pension plans;

190.17 (3) medical expense accounts set up through the person's employer; and

190.18 (4) spousal assets, including spouse's share of jointly held assets.

190.19 (e) All enrollees must pay a premium to be eligible for medical assistance under this  
190.20 subdivision, except as provided under clause (5).

190.21 (1) An enrollee must pay the greater of a ~~\$65~~ \$35 premium or the premium calculated  
190.22 based on the person's gross earned and unearned income and the applicable family size  
190.23 using a sliding fee scale established by the commissioner, which begins at one percent of  
190.24 income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of  
190.25 income for those with incomes at or above 300 percent of the federal poverty guidelines.

190.26 (2) Annual adjustments in the premium schedule based upon changes in the federal  
190.27 poverty guidelines shall be effective for premiums due in July of each year.

190.28 (3) All enrollees who receive unearned income must pay ~~five~~ one-half of one percent  
190.29 of unearned income in addition to the premium amount, except as provided under clause (5).

190.30 (4) Increases in benefits under title II of the Social Security Act shall not be counted  
190.31 as income for purposes of this subdivision until July 1 of each year.

190.32 (5) Effective July 1, 2009, American Indians are exempt from paying premiums as  
190.33 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public  
190.34 Law 111-5. For purposes of this clause, an American Indian is any person who meets the  
190.35 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

191.1 (f) A person's eligibility and premium shall be determined by the local county  
191.2 agency. Premiums must be paid to the commissioner. All premiums are dedicated to  
191.3 the commissioner.

191.4 (g) Any required premium shall be determined at application and redetermined at  
191.5 the enrollee's six-month income review or when a change in income or household size is  
191.6 reported. Enrollees must report any change in income or household size within ten days  
191.7 of when the change occurs. A decreased premium resulting from a reported change in  
191.8 income or household size shall be effective the first day of the next available billing month  
191.9 after the change is reported. Except for changes occurring from annual cost-of-living  
191.10 increases, a change resulting in an increased premium shall not affect the premium amount  
191.11 until the next six-month review.

191.12 (h) Premium payment is due upon notification from the commissioner of the  
191.13 premium amount required. Premiums may be paid in installments at the discretion of  
191.14 the commissioner.

191.15 (i) Nonpayment of the premium shall result in denial or termination of medical  
191.16 assistance unless the person demonstrates good cause for nonpayment. Good cause exists  
191.17 if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to  
191.18 D, are met. Except when an installment agreement is accepted by the commissioner, all  
191.19 persons disenrolled for nonpayment of a premium must pay any past due premiums as well  
191.20 as current premiums due prior to being reenrolled. Nonpayment shall include payment with  
191.21 a returned, refused, or dishonored instrument. The commissioner may require a guaranteed  
191.22 form of payment as the only means to replace a returned, refused, or dishonored instrument.

191.23 (j) For enrollees whose income does not exceed 200 percent of the federal poverty  
191.24 guidelines and who are also enrolled in Medicare, the commissioner shall reimburse  
191.25 the enrollee for Medicare part B premiums under section 256B.0625, subdivision 15,  
191.26 paragraph (a).

191.27 Sec. 9. Minnesota Statutes 2014, section 256B.059, subdivision 5, is amended to read:

191.28 Subd. 5. **Asset availability.** (a) At the time of initial determination of eligibility for  
191.29 medical assistance benefits following the first continuous period of institutionalization on  
191.30 or after October 1, 1989, assets considered available to the institutionalized spouse shall  
191.31 be the total value of all assets in which either spouse has an ownership interest, reduced by  
191.32 the following amount for the community spouse:

191.33 (1) prior to July 1, 1994, the greater of:

191.34 (i) \$14,148;

191.35 (ii) the lesser of the spousal share or \$70,740; or

- 192.1 (iii) the amount required by court order to be paid to the community spouse;
- 192.2 (2) for persons whose date of initial determination of eligibility for medical
- 192.3 assistance following their first continuous period of institutionalization occurs on or after
- 192.4 July 1, 1994, the greater of:
- 192.5 (i) \$20,000;
- 192.6 (ii) the lesser of the spousal share or \$70,740; or
- 192.7 (iii) the amount required by court order to be paid to the community spouse.

192.8 The value of assets transferred for the sole benefit of the community spouse under section

192.9 256B.0595, subdivision 4, in combination with other assets available to the community

192.10 spouse under this section, cannot exceed the limit for the community spouse asset

192.11 allowance determined under subdivision 3 or 4. Assets that exceed this allowance shall be

192.12 considered available to the institutionalized spouse ~~whether or not converted to income~~. If

192.13 the community spouse asset allowance has been increased under subdivision 4, then the

192.14 assets considered available to the institutionalized spouse under this subdivision shall be

192.15 further reduced by the value of additional amounts allowed under subdivision 4.

192.16 (b) An institutionalized spouse may be found eligible for medical assistance even

192.17 though assets in excess of the allowable amount are found to be available under paragraph

192.18 (a) if the assets are owned jointly or individually by the community spouse, and the

192.19 institutionalized spouse cannot use those assets to pay for the cost of care without the

192.20 consent of the community spouse, and if: (i) the institutionalized spouse assigns to the

192.21 commissioner the right to support from the community spouse under section 256B.14,

192.22 subdivision 3; (ii) the institutionalized spouse lacks the ability to execute an assignment

192.23 due to a physical or mental impairment; or (iii) the denial of eligibility would cause an

192.24 imminent threat to the institutionalized spouse's health and well-being.

192.25 (c) After the month in which the institutionalized spouse is determined eligible for

192.26 medical assistance, during the continuous period of institutionalization, no assets of the

192.27 community spouse are considered available to the institutionalized spouse, unless the

192.28 institutionalized spouse has been found eligible under paragraph (b).

192.29 (d) Assets determined to be available to the institutionalized spouse under this

192.30 section must be used for the health care or personal needs of the institutionalized spouse.

192.31 (e) For purposes of this section, assets do not include assets excluded under the

192.32 Supplemental Security Income program.

192.33 Sec. 10. Minnesota Statutes 2014, section 256B.0916, subdivision 2, is amended to read:

192.34 Subd. 2. **Distribution of funds; partnerships.** (a) Beginning with fiscal year 2000,

192.35 the commissioner shall distribute all funding available for home and community-based



193.1 waiver services for persons with developmental disabilities to individual counties or to  
 193.2 groups of counties that form partnerships to jointly plan, administer, and authorize funding  
 193.3 for eligible individuals. The commissioner shall encourage counties to form partnerships  
 193.4 that have a sufficient number of recipients and funding to adequately manage the risk  
 193.5 and maximize use of available resources.

193.6 (b) Counties must submit a request for funds and a plan for administering the  
 193.7 program as required by the commissioner. The plan must identify the number of clients to  
 193.8 be served, their ages, and their priority listing based on:

193.9 (1) requirements in Minnesota Rules, part 9525.1880; and

193.10 (2) statewide priorities identified in section 256B.092, subdivision 12.

193.11 The plan must also identify changes made to improve services to eligible persons and to  
 193.12 improve program management.

193.13 (c) In allocating resources to counties, priority must be given to groups of counties  
 193.14 that form partnerships to jointly plan, administer, and authorize funding for eligible  
 193.15 individuals and to counties determined by the commissioner to have sufficient waiver  
 193.16 capacity to maximize resource use.

193.17 (d) Within 30 days after receiving the county request for funds and plans, the  
 193.18 commissioner shall provide a written response to the plan that includes the level of  
 193.19 resources available to serve additional persons.

193.20 (e) Counties are eligible to receive medical assistance administrative reimbursement  
 193.21 for administrative costs under criteria established by the commissioner.

193.22 (f) The commissioner shall manage waiver allocations in such a manner as to fully  
 193.23 use available state and federal waiver appropriations.

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

193.25 Sec. 11. Minnesota Statutes 2014, section 256B.0916, subdivision 11, is amended to  
 193.26 read:

193.27 Subd. 11. **Excess spending.** County and tribal agencies are responsible for spending  
 193.28 in excess of the allocation made by the commissioner. In the event a county or tribal agency  
 193.29 spends in excess of the allocation made by the commissioner for a given allocation period,  
 193.30 they must submit a corrective action plan to the commissioner for approval. The plan must  
 193.31 state the actions the agency will take to correct their overspending for the year two years  
 193.32 following the period when the overspending occurred. ~~Failure to correct overspending~~  
 193.33 ~~shall result in recoupment of spending in excess of the allocation.~~ The commissioner  
 193.34 shall recoup spending in excess of the allocation only in cases where statewide spending

194.1 exceeds the appropriation designated for the home and community-based services waivers.

194.2 Nothing in this subdivision shall be construed as reducing the county's responsibility to  
194.3 offer and make available feasible home and community-based options to eligible waiver  
194.4 recipients within the resources allocated to them for that purpose.

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

194.6 Sec. 12. Minnesota Statutes 2014, section 256B.0916, is amended by adding a  
194.7 subdivision to read:

194.8 Subd. 12. **Use of waiver allocations.** County and tribal agencies are responsible  
194.9 for spending the annual allocation made by the commissioner. In the event a county or  
194.10 tribal agency spends less than 97 percent of the allocation, while maintaining a list of  
194.11 persons waiting for waiver services, the county or tribal agency must submit a corrective  
194.12 action plan to the commissioner for approval. The commissioner may determine a plan  
194.13 is unnecessary given the size of the allocation and capacity for new enrollment. The  
194.14 plan must state the actions the agency will take to assure reasonable and timely access  
194.15 to home and community-based waiver services for persons waiting for services. If a  
194.16 county or tribe does not submit a plan when required or implement the changes required,  
194.17 the commissioner shall assure access to waiver services within the county's or tribe's  
194.18 available allocation and take other actions needed to assure that all waiver participants in  
194.19 that county or tribe are receiving appropriate waiver services to meet their needs.

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

194.21 Sec. 13. Minnesota Statutes 2014, section 256B.441, is amended by adding a  
194.22 subdivision to read:

194.23 Subd. 65. **Nursing facility workforce enhancement rate adjustment effective**  
194.24 **January 1, 2016.** (a) A onetime rate adjustment for the purpose of providing more  
194.25 competitive wages in nursing facilities shall be provided as described under this  
194.26 subdivision.

194.27 (b) Beginning January 1, 2016, the commissioner shall make available to each  
194.28 nursing facility reimbursed under this section an operating payment rate adjustment,  
194.29 in accordance with paragraphs (c) to (i).

194.30 (c) One hundred percent of the money resulting from the rate adjustment under  
194.31 paragraph (b) must be used for increases in wages and the employer's share of FICA taxes,  
194.32 Medicare taxes, state and federal unemployment taxes, and workers' compensation for

195.1 employees directly employed by the nursing facility on or after the effective date of the  
195.2 rate adjustment. Individuals not eligible for an increase under this subdivision include:

195.3 (1) an individual employed in the central office of an entity that has an ownership  
195.4 interest in the nursing facility or exercises control over the nursing facility;

195.5 (2) an individual paid by the nursing facility under a management contract; or

195.6 (3) an individual being paid a base wage of \$40 per hour or more.

195.7 (d) A nursing facility may apply for the rate adjustment under paragraph (b). The

195.8 application must be submitted to the commissioner, in the form and manner specified by

195.9 the commissioner, by August 10, 2015, and the nursing facility must provide additional

195.10 information required by the commissioner by October 1, 2015. The commissioner may

195.11 waive the deadlines in this paragraph under extraordinary circumstances, to be determined

195.12 at the sole discretion of the commissioner. The application must contain at least:

195.13 (1) labor market information for positions that in terms of training, experience, and  
195.14 other relevant qualifications, are comparable to those in the nursing facility;

195.15 (2) proposed wage plan changes according to which all employees in a specific job

195.16 group receive wage adjustments by an equal percentage, and that result in the average

195.17 cost per compensated hour for that job group being equal to those for the comparable

195.18 positions in the labor market;

195.19 (3) a calculation of the cost of implementing the specified wage plans;

195.20 (4) for nursing facilities in which ten percent or more of eligible employees are

195.21 represented by an exclusive bargaining representative, the commissioner shall approve

195.22 the application only upon receipt of a letter of acceptance of the distribution plan, with

195.23 respect to members of the bargaining unit, signed by the exclusive bargaining agent and

195.24 dated after May 25, 2015;

195.25 (5) a description of the plan the nursing facility will follow to notify eligible

195.26 employees of the contents of the approved application. The plan must provide for giving

195.27 each eligible employee a copy of the approved application or posting a copy of the

195.28 approved application for a period of at least six weeks in an area of the nursing facility to

195.29 which all eligible employees have access; and

195.30 (6) instructions for employees who believe they have not received the

195.31 compensation-related increases specified in clause (2), as approved by the commissioner,

195.32 and that must include a mailing address, e-mail address, and the telephone number that may

195.33 be used by the employee to contact the commissioner or the commissioner's representative.

195.34 (e) The commissioner shall review applications received and shall subject them to

195.35 tests for consistency with the most recently available information from annual statistical

195.36 and cost reports. The commission shall request additional information as needed from

196.1 applying facilities. By use of medians from all applications and the most recently available  
196.2 public data on regional prevailing wage levels for comparable positions, the commissioner  
196.3 shall adjust the applicant-provided labor market information used in determining the  
196.4 amount of funding increase to be provided.

196.5 (f) The commissioner shall review applications received under paragraph (d) and  
196.6 shall provide the funding increase under this subdivision if the requirements of this  
196.7 subdivision have been met and if the appropriation for this purpose is sufficient. The rate  
196.8 adjustment shall be effective January 1, 2016. If the approved applications, in total, would  
196.9 distribute more money than is appropriated, the commissioner shall reduce by an equal  
196.10 percentage the amount of all funding increases to be allowed. The wage adjustments  
196.11 specified in an application may be reduced by the same percentage.

196.12 (g) For direct care-related positions, the commissioner shall divide the amount  
196.13 determined in paragraph (f) by the standardized days from the most recently available cost  
196.14 report and multiply this amount by the weight assigned to each RUG class, to determine  
196.15 per diem amounts, which shall be added to each RUG operating payment rate.

196.16 (h) For all other positions, the commissioner shall divide the amount determined in  
196.17 paragraph (f) by the resident days from the most recently available cost report and add this  
196.18 amount to each RUG operating payment rate.

196.19 (i) A nursing facility participating in the equitable cost-sharing for publicly owned  
196.20 nursing facility program participation under section 256B.441, subdivision 55a, may  
196.21 amend its level of participation after receiving notice of approval of its application under  
196.22 this subdivision.

196.23 Sec. 14. Minnesota Statutes 2014, section 256B.49, subdivision 26, is amended to read:

196.24 Subd. 26. **Excess allocations.** (a) Effective through June 30, 2018, county and  
196.25 tribal agencies will be responsible for authorizations in excess of the annual allocation  
196.26 made by the commissioner. In the event a county or tribal agency authorizes in excess  
196.27 of the allocation made by the commissioner for a given allocation period, the county or  
196.28 tribal agency must submit a corrective action plan to the commissioner for approval.  
196.29 The plan must state the actions the agency will take to correct their overspending for  
196.30 the ~~year~~ two years following the period when the overspending occurred. ~~Failure to~~  
196.31 ~~correct over~~authorizations shall result in recoupment of authorizations in excess of the  
196.32 ~~allocation~~. The commissioner shall recoup funds spent in excess of the allocation only  
196.33 in cases where statewide spending exceeds the appropriation designated for the home  
196.34 and community-based services waivers. Nothing in this subdivision shall be construed  
196.35 as reducing the county's responsibility to offer and make available feasible home and

197.1 community-based options to eligible waiver recipients within the resources allocated  
197.2 to them for that purpose. If a county or tribe does not submit a plan when required or  
197.3 implement the changes required, the commissioner shall assure access to waiver services  
197.4 within the county's or tribe's available allocation and take other actions needed to assure  
197.5 that all waiver participants in that county or tribe are receiving appropriate waiver services  
197.6 to meet their needs.

197.7 (b) Effective July 1, 2018, county and tribal agencies will be responsible for  
197.8 spending in excess of the annual allocation made by the commissioner. In the event a  
197.9 county or tribal agency spends in excess of the allocation made by the commissioner for a  
197.10 given allocation period, the county or tribal agency must submit a corrective action plan to  
197.11 the commissioner for approval. The plan must state the actions the agency will take to  
197.12 correct its overspending for the two years following the period when the overspending  
197.13 occurred. The commissioner shall recoup funds spent in excess of the allocation only  
197.14 in cases when statewide spending exceeds the appropriation designated for the home  
197.15 and community-based services waivers. Nothing in this subdivision shall be construed  
197.16 as reducing the county's responsibility to offer and make available feasible home and  
197.17 community-based options to eligible waiver recipients within the resources allocated to it  
197.18 for that purpose. If a county or tribe does not submit a plan when required or implement  
197.19 the changes required, the commissioner shall assure access to waiver services within  
197.20 the county's or tribe's available allocation and take other actions needed to assure that  
197.21 all waiver participants in that county or tribe are receiving appropriate waiver services  
197.22 to meet their needs.

197.23 Sec. 15. Minnesota Statutes 2014, section 256B.49, is amended by adding a  
197.24 subdivision to read:

197.25 Subd. 27. **Use of waiver allocations.** (a) Effective until June 30, 2018, county  
197.26 and tribal agencies are responsible for authorizing the annual allocation made by the  
197.27 commissioner. In the event a county or tribal agency authorizes less than 97 percent of  
197.28 the allocation, while maintaining a list of persons waiting for waiver services, the county  
197.29 or tribal agency must submit a corrective action plan to the commissioner for approval.  
197.30 The commissioner may determine a plan is unnecessary given the size of the allocation  
197.31 and capacity for new enrollment. The plan must state the actions the agency will take  
197.32 to assure reasonable and timely access to home and community-based waiver services  
197.33 for persons waiting for services.

197.34 (b) Effective July 1, 2018, county and tribal agencies are responsible for spending  
197.35 the annual allocation made by the commissioner. In the event a county or tribal agency

198.1 spends less than 97 percent of the allocation, while maintaining a list of persons waiting  
198.2 for waiver services, the county or tribal agency must submit a corrective action plan to the  
198.3 commissioner for approval. The commissioner may determine a plan is unnecessary given  
198.4 the size of the allocation and capacity for new enrollment. The plan must state the actions  
198.5 the agency will take to assure reasonable and timely access to home and community-based  
198.6 waiver services for persons waiting for services.

198.7 Sec. 16. Minnesota Statutes 2014, section 256B.4913, subdivision 4a, is amended to  
198.8 read:

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

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

198.18 (1) for a day service recipient who was not authorized to receive these waiver  
198.19 services prior to January 1, 2014; added a new service or services on or after January 1,  
198.20 2014; or changed providers on or after January 1, 2014, the historical rate must be the  
198.21 authorized rate for the provider in the county of service, effective December 1, 2013; or

198.22 (2) for a unit-based service with programming or a unit-based service without  
198.23 programming recipient who was not authorized to receive these waiver services prior to  
198.24 January 1, 2014; added a new service or services on or after January 1, 2014; or changed  
198.25 providers on or after January 1, 2014, the historical rate must be the weighted average  
198.26 authorized rate for each provider number in the county of service, effective December 1,  
198.27 2013; or

198.28 (3) for residential service recipients who change providers on or after January 1,  
198.29 2014, the historical rate must be set by each lead agency within their county aggregate  
198.30 budget using their respective methodology for residential services effective December 1,  
198.31 2013, for determining the provider rate for a similarly situated recipient being served by  
198.32 that provider.

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

198.35 (1) 0.5 percent from the historical rate for the implementation period;

199.1 (2) 0.5 percent from the rate in effect in clause (1), for the 12-month period  
 199.2 immediately following the time period of clause (1);

199.3 (3) ~~1.0~~ 0.5 percent from the rate in effect in clause (2), for the 12-month period  
 199.4 immediately following the time period of clause (2);

199.5 (4) 1.0 percent from the rate in effect in clause (3), for the 12-month period  
 199.6 immediately following the time period of clause (3); ~~and~~

199.7 (5) 1.0 percent from the rate in effect in clause (4), for the 12-month period  
 199.8 immediately following the time period of clause (4); and

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

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

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

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

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

199.25 (2) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or  
 199.26 9, for the individual with variables reflecting the updated level of service at the time  
 199.27 of application; and

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

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

199.33 Sec. 17. Minnesota Statutes 2014, section 256B.4913, subdivision 5, is amended to read:

199.34 Subd. 5. **Stakeholder consultation and county training.** (a) The commissioner  
 199.35 shall continue consultation on regular intervals with the existing stakeholder group

200.1 established as part of the rate-setting methodology process and others, to gather input,  
200.2 concerns, and data, to assist in the full implementation of the new rate payment system and  
200.3 to make pertinent information available to the public through the department's Web site.

200.4 (b) The commissioner shall offer training at least annually for county personnel  
200.5 responsible for administering the rate-setting framework in a manner consistent with this  
200.6 section and section 256B.4914.

200.7 (c) The commissioner shall maintain an online instruction manual explaining the  
200.8 rate-setting framework. The manual shall be consistent with this section and section  
200.9 256B.4914, and shall be accessible to all stakeholders including recipients, representatives  
200.10 of recipients, county or tribal agencies, and license holders.

200.11 (d) The commissioner shall not defer to the county or tribal agency on matters of  
200.12 technical application of the rate-setting framework, and a county or tribal agency shall not  
200.13 set rates in a manner that conflicts with this section or section 256B.4914.

200.14 Sec. 18. Minnesota Statutes 2014, section 256B.4914, subdivision 2, is amended to read:

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

201.28 (2) for day services under subdivision 7:

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

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

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

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

- 202.1 (ii) for adult day and structured day services, a unit of service is a day or 15 minutes.  
 202.2 A day unit of service is six or more hours of time spent providing direct services;  
 202.3 (iii) for prevocational services, a unit of service is a day or an hour. A day unit of  
 202.4 service is six or more hours of time spent providing direct service;  
 202.5 (3) for unit-based services with programming under subdivision 8:  
 202.6 (i) for supported living services, a unit of service is a day or 15 minutes. When a  
 202.7 day rate is authorized, any portion of a calendar day where an individual receives services  
 202.8 is billable as a day; and  
 202.9 (ii) for all other services, a unit of service is 15 minutes; and  
 202.10 (4) for unit-based services without programming under subdivision 9:  
 202.11 (i) for respite services, a unit of service is a day or 15 minutes. When a day rate is  
 202.12 authorized, any portion of a calendar day when an individual receives services is billable  
 202.13 as a day; and  
 202.14 (ii) for all other services, a unit of service is 15 minutes.

202.15 Sec. 19. Minnesota Statutes 2014, section 256B.4914, subdivision 8, is amended to read:

202.16 Subd. 8. **Payments for unit-based services with programming.** Payments for  
 202.17 unit-based ~~with program~~ services with programming, including behavior programming,  
 202.18 housing access coordination, in-home family support, independent living skills training,  
 202.19 hourly supported living services, and supported employment provided to an individual  
 202.20 outside of any day or residential service plan must be calculated as follows, unless the  
 202.21 services are authorized separately under subdivision 6 or 7:

- 202.22 (1) determine the number of units of service to meet a recipient's needs;  
 202.23 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics  
 202.24 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;  
 202.25 (3) for a recipient requiring customization for deaf and hard-of-hearing language  
 202.26 accessibility under subdivision 12, add the customization rate provided in subdivision 12  
 202.27 to the result of clause (2). This is defined as the customized direct-care rate;  
 202.28 (4) multiply the number of direct staff hours by the appropriate staff wage in  
 202.29 subdivision 5, paragraph (a), or the customized direct-care rate;  
 202.30 (5) multiply the number of direct staff hours by the product of the supervision span  
 202.31 of control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision  
 202.32 wage in subdivision 5, paragraph (a), clause (16);  
 202.33 (6) combine the results of clauses (4) and (5), and multiply the result by one plus  
 202.34 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (e),  
 202.35 clause (2). This is defined as the direct staffing rate;

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

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

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

203.7 (10) this is the subtotal rate;

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

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

203.12 (13) for supported employment provided in a shared manner, divide the total  
203.13 payment amount in clause (12) by the number of service recipients, not to exceed three.

203.14 For independent living skills training provided in a shared manner, divide the total  
203.15 payment amount in clause (12) by the number of service recipients, not to exceed two; and

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

203.18 Sec. 20. Minnesota Statutes 2014, section 256B.4914, subdivision 10, is amended to  
203.19 read:

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

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

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

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

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

203.34 (c) Using a statistically valid set of rates management system data, the commissioner,  
203.35 in consultation with stakeholders, shall analyze for each service the average difference

204.1 in the rate on December 31, 2013, and the framework rate at the individual, provider,  
204.2 lead agency, and state levels. The commissioner shall issue semiannual reports to the  
204.3 stakeholders on the difference in rates by service and by county during the banding period  
204.4 under section 256B.4913, subdivision 4a. The commissioner shall issue the first report  
204.5 by October 1, 2014.

204.6 (d) No later than July 1, 2014, the commissioner, in consultation with stakeholders,  
204.7 shall begin the review and evaluation of the following values already in subdivisions 6 to  
204.8 9, or issues that impact all services, including, but not limited to:

- 204.9 (1) values for transportation rates for day services;
- 204.10 (2) values for transportation rates in residential services;
- 204.11 (3) values for services where monitoring technology replaces staff time;
- 204.12 (4) values for indirect services;
- 204.13 (5) values for nursing;
- 204.14 (6) component values for independent living skills;
- 204.15 (7) component values for family foster care that reflect licensing requirements;
- 204.16 (8) adjustments to other components to replace the budget neutrality factor;
- 204.17 (9) remote monitoring technology for nonresidential services;
- 204.18 (10) values for basic and intensive services in residential services;
- 204.19 (11) ~~values for the facility use rate in day services~~ the weightings used in the day  
204.20 service ratios and adjustments to those weightings;
- 204.21 (12) values for workers' compensation as part of employee-related expenses;
- 204.22 (13) values for unemployment insurance as part of employee-related expenses;
- 204.23 (14) a component value to reflect costs for individuals with rates previously adjusted  
204.24 for the inclusion of group residential housing rate 3 costs, only for any individual enrolled  
204.25 as of December 31, 2013; and
- 204.26 (15) any changes in state or federal law with an impact on the underlying cost of  
204.27 providing home and community-based services.

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

- 204.32 (1) January 15, 2015, with preliminary results and data;
- 204.33 (2) January 15, 2016, with a status implementation update, and additional data  
204.34 and summary information;
- 204.35 (3) January 15, 2017, with the full report; and

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

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

205.8 (g) The commissioner shall implement a regional adjustment factor to all rate  
205.9 calculations in subdivisions 6 to 9, effective no later than January 1, 2015. Prior to  
205.10 implementation, the commissioner shall consult with stakeholders on the methodology to  
205.11 calculate the adjustment.

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

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

205.17 (2) service utilization;

205.18 (3) county and tribal allocation changes; and

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

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

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

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

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

206.1 Sec. 21. Minnesota Statutes 2014, section 256B.4914, subdivision 14, is amended to  
206.2 read:

206.3 Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead  
206.4 agencies must identify individuals with exceptional needs that cannot be met under the  
206.5 disability waiver rate system. The commissioner shall use that information to evaluate  
206.6 and, if necessary, approve an alternative payment rate for those individuals. Whether  
206.7 granted, denied, or modified, the commissioner shall respond to all exception requests in  
206.8 writing. The commissioner shall include in the written response the basis for the action  
206.9 and provide notification of the right to appeal under paragraph (h).

206.10 (b) Lead agencies must act on an exception request within 30 days and notify the  
206.11 initiator of the request of their recommendation in writing. A lead agency shall submit all  
206.12 exception requests along with its recommendation to the state commissioner.

206.13 (c) An application for a rate exception may be submitted for the following criteria:

206.14 (1) an individual has service needs that cannot be met through additional units  
206.15 of service; ~~or~~

206.16 (2) an individual's rate determined under subdivisions 6, 7, 8, and 9 results is so  
206.17 insufficient that it has resulted in an individual being discharged receiving a notice of  
206.18 discharge from the individual's provider; or

206.19 (3) an individual's service needs, including behavioral changes, require a level of  
206.20 service which necessitates a change in provider or which requires the current provider to  
206.21 propose service changes beyond those currently authorized.

206.22 (d) Exception requests must include the following information:

206.23 (1) the service needs required by each individual that are not accounted for in  
206.24 subdivisions 6, 7, 8, and 9;

206.25 (2) the service rate requested and the difference from the rate determined in  
206.26 subdivisions 6, 7, 8, and 9;

206.27 (3) a basis for the underlying costs used for the rate exception and any accompanying  
206.28 documentation; and

206.29 (4) ~~the duration of the rate exception; and~~

206.30 (5) any contingencies for approval.

206.31 (e) Approved rate exceptions shall be managed within lead agency allocations under  
206.32 sections 256B.092 and 256B.49.

206.33 (f) Individual disability waiver recipients, an interested party, or the license holder  
206.34 that would receive the rate exception increase may request that a lead agency submit an  
206.35 exception request. A lead agency that denies such a request shall notify the individual  
206.36 waiver recipient, interested party, or license holder of its decision and the reasons for

207.1 denying the request in writing no later than 30 days after the individual's request has been  
207.2 made and shall submit its denial to the commissioner in accordance with paragraph (b).  
207.3 The reasons for the denial must be based on the failure to meet the criteria in paragraph (c).

207.4 (g) The commissioner shall determine whether to approve or deny an exception  
207.5 request no more than 30 days after receiving the request. If the commissioner denies the  
207.6 request, the commissioner shall notify the lead agency and the individual disability waiver  
207.7 recipient, the interested party, and the license holder in writing of the reasons for the denial.

207.8 (h) The individual disability waiver recipient may appeal any denial of an exception  
207.9 request by either the lead agency or the commissioner, pursuant to sections 256.045 and  
207.10 256.0451. When the denial of an exception request results in the proposed demission of a  
207.11 waiver recipient from a residential or day habilitation program, the commissioner shall  
207.12 issue a temporary stay of demission, when requested by the disability waiver recipient,  
207.13 consistent with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c).  
207.14 The temporary stay shall remain in effect until the lead agency can provide an informed  
207.15 choice of appropriate, alternative services to the disability waiver.

207.16 (i) Providers may petition lead agencies to update values that were entered  
207.17 incorrectly or erroneously into the rate management system, based on past service level  
207.18 discussions and determination in subdivision 4, without applying for a rate exception.

207.19 (j) The starting date for the rate exception will be the later of the date of the  
207.20 recipient's change in support or the date of the request to the lead agency for an exception.

207.21 (k) The commissioner shall track all exception requests received and their  
207.22 dispositions. The commissioner shall issue quarterly public exceptions statistical reports,  
207.23 including the number of exception requests received and the numbers granted, denied,  
207.24 withdrawn, and pending. The report shall include the average amount of time required to  
207.25 process exceptions.

207.26 (l) No later than January 15, 2016, the commissioner shall provide research  
207.27 findings on the estimated fiscal impact, the primary cost drivers, and common population  
207.28 characteristics of recipients with needs that cannot be met by the framework rates.

207.29 (m) No later than July 1, 2016, the commissioner shall develop and implement,  
207.30 in consultation with stakeholders, a process to determine eligibility for rate exceptions  
207.31 for individuals with rates determined under the methodology in section 256B.4913,  
207.32 subdivision 4a. Determination of eligibility for an exception will occur as annual service  
207.33 renewals are completed.

207.34 (n) Approved rate exceptions will be implemented at such time that the individual's  
207.35 rate is no longer banded and remain in effect in all cases until an individual's needs change  
207.36 as defined in paragraph (c).

208.1 Sec. 22. Minnesota Statutes 2014, section 256B.4914, subdivision 15, is amended to  
208.2 read:

208.3 Subd. 15. **County or tribal allocations.** (a) Upon implementation of the disability  
208.4 waiver rates management system on January 1, 2014, the commissioner shall establish  
208.5 a method of tracking and reporting the fiscal impact of the disability waiver rates  
208.6 management system on individual lead agencies.

208.7 (b) Beginning January 1, 2014, the commissioner shall make annual adjustments to  
208.8 lead agencies' home and community-based waived service budget allocations to adjust  
208.9 for rate differences and the resulting impact on county allocations upon implementation of  
208.10 the disability waiver rates system.

208.11 (c) ~~During the first two years of implementation under section 256B.4913, Lead~~  
208.12 ~~agencies exceeding their allocations shall be subject to the provisions under sections~~  
208.13 ~~256B.092 256B.0916, subdivision 11, and 256B.49 shall only be held liable for spending~~  
208.14 ~~in excess of their allocations after a reallocation of resources by the commissioner under~~  
208.15 ~~paragraph (b). The commissioner shall reallocate resources under sections 256B.092,~~  
208.16 ~~subdivision 12, and 256B.49, subdivision 11a. The commissioner shall notify lead~~  
208.17 ~~agencies of this process by July 1, 2014 256B.49, subdivision 26.~~

208.18 Sec. 23. **[256Q.01] PLAN ESTABLISHED.**

208.19 A savings plan known as the Minnesota ABLE plan is established. In establishing  
208.20 this plan, the legislature seeks to encourage and assist individuals and families in saving  
208.21 private funds for the purpose of supporting individuals with disabilities to maintain health,  
208.22 independence, and quality of life, and to provide secure funding for disability-related  
208.23 expenses on behalf of designated beneficiaries with disabilities that will supplement, but  
208.24 not supplant, benefits provided through private insurance, federal and state medical and  
208.25 disability insurance, the beneficiary's employment, and other sources.

208.26 Sec. 24. **[256Q.02] CITATION.**

208.27 This chapter may be cited as the "Minnesota Achieving a Better Life Experience  
208.28 Act" or "Minnesota ABLE Act."

208.29 Sec. 25. **[256Q.03] DEFINITIONS.**

208.30 Subdivision 1. **Scope.** For the purposes of this chapter, the terms defined in this  
208.31 section have the meanings given them.

208.32 Subd. 2. **ABLE account.** "ABLE account" has the meaning defined in section  
208.33 529A(e)(6) of the Internal Revenue Code.



209.1 Subd. 3. **ABLE account plan or plan.** "ABLE account plan" or "plan" means the  
209.2 qualified ABLE program, as defined in section 529A(b) of the Internal Revenue Code,  
209.3 provided for in this chapter.

209.4 Subd. 4. **Account.** "Account" means the formal record of transactions relating to an  
209.5 ABLE plan beneficiary.

209.6 Subd. 5. **Account owner.** "Account owner" means the designated beneficiary  
209.7 of the account.

209.8 Subd. 6. **Annual contribution limit.** "Annual contribution limit" has the meaning  
209.9 defined in section 529A(b)(2) of the Internal Revenue Code.

209.10 Subd. 7. **Application.** "Application" means the form executed by a prospective  
209.11 account owner to enter into a participation agreement and open an account in the plan.  
209.12 The application incorporates by reference the participation agreement.

209.13 Subd. 8. **Board.** "Board" means the State Board of Investment.

209.14 Subd. 9. **Commissioner.** "Commissioner" means the commissioner of human  
209.15 services.

209.16 Subd. 10. **Contribution.** "Contribution" means a payment directly allocated to  
209.17 an account for the benefit of a beneficiary.

209.18 Subd. 11. **Department.** "Department" means the Department of Human Services.

209.19 Subd. 12. **Designated beneficiary or beneficiary.** "Designated beneficiary" or  
209.20 "beneficiary" has the meaning given in section 529A(e)(3) of the Internal Revenue Code  
209.21 and further defined through regulations issued under that section.

209.22 Subd. 13. **Earnings.** "Earnings" means the total account balance minus the  
209.23 investment in the account.

209.24 Subd. 14. **Eligible individual.** "Eligible individual" has the meaning defined in  
209.25 section 529A(e)(1) of the Internal Revenue Code and further defined through regulations  
209.26 issued under that section.

209.27 Subd. 15. **Executive director.** "Executive director" means the executive director of  
209.28 the State Board of Investment.

209.29 Subd. 16. **Internal Revenue Code.** "Internal Revenue Code" means the Internal  
209.30 Revenue Code of 1986, as amended.

209.31 Subd. 17. **Investment in the account.** "Investment in the account" means the sum  
209.32 of all contributions made to an account by a particular date minus the aggregate amount  
209.33 of contributions included in distributions or rollover distributions, if any, made from the  
209.34 account as of that date.

209.35 Subd. 18. **Member of the family.** "Member of the family" has the meaning defined  
209.36 in section 529A(e)(4) of the Internal Revenue Code.

210.1 Subd. 19. **Participation agreement.** "Participation agreement" means an agreement  
210.2 to participate in the Minnesota ABLE plan between an account owner and the state,  
210.3 through its agencies, the commissioner, and the board.

210.4 Subd. 20. **Person.** "Person" means an individual, trust, estate, partnership,  
210.5 association, company, corporation, or the state.

210.6 Subd. 21. **Plan administrator.** "Plan administrator" means the person selected by  
210.7 the commissioner and the board to administer the daily operations of the ABLE account  
210.8 plan and provide marketing, record keeping, investment management, and other services  
210.9 for the plan.

210.10 Subd. 22. **Qualified disability expense.** "Qualified disability expense" has the  
210.11 meaning defined in section 529A(e)(5) of the Internal Revenue Code and further defined  
210.12 through regulations issued under that section.

210.13 Subd. 23. **Qualified distribution.** "Qualified distribution" means a withdrawal from  
210.14 an ABLE account to pay the qualified disability expenses of the beneficiary of the account.  
210.15 A qualified withdrawal may be made by the beneficiary, by an agent of the beneficiary  
210.16 who has the power of attorney, or by the beneficiary's legal guardian.

210.17 Subd. 24. **Rollover distribution.** "Rollover distribution" means a transfer of funds  
210.18 made:

210.19 (1) from one account in another state's qualified ABLE program to an account for  
210.20 the benefit of the same designated beneficiary or an eligible individual who is a family  
210.21 member of the former designated beneficiary; or

210.22 (2) from one account to another account for the benefit of an eligible individual who  
210.23 is a family member of the former designated beneficiary.

210.24 Subd. 25. **Total account balance.** "Total account balance" means the amount in an  
210.25 account on a particular date or the fair market value of an account on a particular date.

210.26 Sec. 26. **[256Q.04] ABLE PLAN REQUIREMENTS.**

210.27 Subdivision 1. **State residency requirement.** The designated beneficiary of any  
210.28 ABLE account must be a resident of Minnesota, or the resident of a state that has entered  
210.29 into a contract with Minnesota to provide its residents access to the Minnesota ABLE plan.

210.30 Subd. 2. **Single account requirement.** No more than one ABLE account shall be  
210.31 established per beneficiary, except as permitted under section 529A(c)(4) of the Internal  
210.32 Revenue Code.

210.33 Subd. 3. **Accounts-type plan.** The plan must be operated as an accounts-type  
210.34 plan. A separate account must be maintained for each designated beneficiary for whom  
210.35 contributions are made.

211.1 Subd. 4. **Contribution and account requirements.** Contributions to an ABLE  
211.2 account are subject to the requirements of section 529A(b)(2) of the Internal Revenue  
211.3 Code prohibiting noncash contributions and contributions in excess of the annual  
211.4 contribution limit. The total account balance may not exceed the maximum account  
211.5 balance limit imposed under section 136G.09, subdivision 8.

211.6 Subd. 5. **Limited investment direction.** Designated beneficiaries may not direct  
211.7 the investment of assets in their accounts more than twice in any calendar year.

211.8 Subd. 6. **Security for loans.** An interest in an account must not be used as security  
211.9 for a loan.

211.10 Sec. 27. **[256Q.05] ABL PLAN ADMINISTRATION.**

211.11 Subdivision 1. **Plan to comply with federal law.** The commissioner shall ensure that  
211.12 the plan meets the requirements for an ABL account under section 529A of the Internal  
211.13 Revenue Code. The commissioner may request a private letter ruling or rulings from the  
211.14 Internal Revenue Service or Secretary of Health and Human Services and must take any  
211.15 necessary steps to ensure that the plan qualifies under relevant provisions of federal law.

211.16 Subd. 2. **Plan rules and procedures.** (a) The commissioner shall establish the  
211.17 rules, terms, and conditions for the plan, subject to the requirements of this chapter and  
211.18 section 529A of the Internal Revenue Code.

211.19 (b) The commissioner shall prescribe the application forms, procedures, and other  
211.20 requirements that apply to the plan.

211.21 Subd. 3. **Consultation with other state agencies.** In designing and establishing  
211.22 the plan's requirements and in negotiating or entering into contracts with third parties  
211.23 under subdivision 4, the commissioner shall consult with the executive director of the  
211.24 State Board of Investment and the commissioner of the Office of Higher Education.  
211.25 The commissioner and the executive director shall establish an annual fee, equal to a  
211.26 percentage of the average daily net assets of the plan, to be imposed on account owners  
211.27 to recover the costs of administration, record keeping, and investment management as  
211.28 provided in subdivision 5, and section 256Q.07, subdivision 4.

211.29 Subd. 4. **Administration.** The commissioner shall administer the plan, including  
211.30 accepting and processing applications, verifying state residency, verifying eligibility,  
211.31 maintaining account records, making payments, and undertaking any other necessary  
211.32 tasks to administer the plan. Notwithstanding other requirements of this chapter, the  
211.33 commissioner shall adopt rules for purposes of implementing and administering the plan.  
211.34 The commissioner may contract with one or more third parties to carry out some or all of  
211.35 these administrative duties, including providing incentives. The commissioner and the

212.1 board may jointly contract with third-party providers, if the commissioner and board  
 212.2 determine that it is desirable to contract with the same entity or entities for administration  
 212.3 and investment management.

212.4 Subd. 5. **Authority to impose fees.** The commissioner may impose annual fees,  
 212.5 as provided in subdivision 3, on account owners to recover the costs of administration.  
 212.6 The commissioner must keep the fees as low as possible, consistent with efficient  
 212.7 administration, so that the returns on savings invested in the plan are as high as possible.

212.8 Subd. 6. **Federally mandated reporting.** (a) As required under section 529A(d) of  
 212.9 the Internal Revenue Code, the commissioner or the commissioner's designee shall submit  
 212.10 a notice to the Secretary of the Treasury upon the establishment of each ABLE account.  
 212.11 The notice must contain the name and state of residence of the designated beneficiary and  
 212.12 other information as the secretary may require.

212.13 (b) As required under section 529A(d) of the Internal Revenue Code, the  
 212.14 commissioner or the commissioner's designee shall submit electronically on a monthly  
 212.15 basis to the Commissioner of Social Security, in a manner specified by the Commissioner  
 212.16 of Social Security, statements on relevant distributions and account balances from all  
 212.17 ABLE accounts.

212.18 Subd. 7. **Data.** (a) Data on ABLE accounts and designated beneficiaries of ABLE  
 212.19 accounts are private data on individuals or nonpublic data as defined in section 13.02.

212.20 (b) The commissioner may share or disseminate data classified as private or  
 212.21 nonpublic in this subdivision as follows:

212.22 (1) with other state or federal agencies, only to the extent necessary to verify  
 212.23 identity of, determine the eligibility of, or process applications for an eligible individual  
 212.24 participating in the Minnesota ABLE plan; and

212.25 (2) with a nongovernmental person, only to the extent necessary to carry out the  
 212.26 functions of the Minnesota ABLE plan, provided the commissioner has entered into  
 212.27 a data-sharing agreement with the person, as provided in section 13.05, subdivision 6,  
 212.28 prior to sharing data under this clause or a contract with that person that complies with  
 212.29 section 13.05, subdivision 11, as applicable.

212.30 Sec. 28. **[256Q.06] PLAN ACCOUNTS.**

212.31 Subdivision 1. **Contributions to an account.** Any person may make contributions  
 212.32 to an ABLE account on behalf of a designated beneficiary. Contributions to an account  
 212.33 made by persons other than the account owner become the property of the account owner.  
 212.34 A person does not acquire an interest in an ABLE account by making contributions to  
 212.35 an account. Contributions to an account must be made in cash, by check, or by other

213.1 commercially acceptable means, as permitted by the United States Internal Revenue  
213.2 Service and approved by the plan administrator in cooperation with the commissioner  
213.3 and the board.

213.4 Subd. 2. **Contribution and account limitations.** Contributions to an ABLE  
213.5 account are subject to the requirements of section 529A(b) of the Internal Revenue Code.  
213.6 The total account balance of an ABLE account may not exceed the maximum account  
213.7 balance limit imposed under section 136G.09, subdivision 8. The plan administrator must  
213.8 reject any portion of a contribution to an account that exceeds the annual contribution limit  
213.9 or that would cause the total account balance to exceed the maximum account balance  
213.10 limit imposed under section 136G.09, subdivision 8.

213.11 Subd. 3. **Authority of account owner.** An account owner is the only person  
213.12 entitled to:

213.13 (1) request distributions;

213.14 (2) request rollover distributions; or

213.15 (3) change the beneficiary of an ABLE account to a member of the family of the  
213.16 current beneficiary, but only if the beneficiary to whom the ABLE account is transferred  
213.17 is an eligible individual.

213.18 Subd. 4. **Effect of plan changes on participation agreement.** Amendments to  
213.19 this chapter automatically amend the participation agreement. Any amendments to the  
213.20 operating procedures and policies of the plan automatically amend the participation  
213.21 agreement after adoption by the commissioner or the board.

213.22 Subd. 5. **Special account to hold plan assets in trust.** All assets of the plan,  
213.23 including contributions to accounts, are held in trust for the exclusive benefit of account  
213.24 owners. Assets must be held in a separate account in the state treasury to be known as  
213.25 the Minnesota ABLE plan account or in accounts with the third-party provider selected  
213.26 pursuant to section 256Q.05, subdivision 4. Plan assets are not subject to claims by creditors  
213.27 of the state, are not part of the general fund, and are not subject to appropriation by the  
213.28 state. Payments from the Minnesota ABLE plan account shall be made under this chapter.

213.29 Sec. 29. **[256Q.07] INVESTMENT OF ABLE ACCOUNTS.**

213.30 Subdivision 1. **State Board of Investment to invest.** The State Board of Investment  
213.31 shall invest the money deposited in accounts in the plan.

213.32 Subd. 2. **Permitted investments.** The board may invest the accounts in any  
213.33 permitted investment under section 11A.24, except that the accounts may be invested  
213.34 without limit in investment options from open-ended investment companies registered

214.1 under the federal Investment Company Act of 1940, United States Code, title 15, sections  
214.2 80a-1 to 80a-64.

214.3 Subd. 3. **Contracting authority.** The board may contract with one or more third  
214.4 parties for investment management, record keeping, or other services in connection with  
214.5 investing the accounts. The board and commissioner may jointly contract with third-party  
214.6 providers, if the commissioner and board determine that it is desirable to contract with the  
214.7 same entity or entities for administration and investment management.

214.8 Subd. 4. **Fees.** The board may impose annual fees, as provided in section 256Q.05,  
214.9 subdivision 3, on account owners to recover the cost of investment management and  
214.10 related tasks for the plan. The board must use its best efforts to keep these fees as low  
214.11 as possible, consistent with high quality investment management, so that the returns on  
214.12 savings invested in the plan will be as high as possible.

214.13 Sec. 30. **[256Q.08] ACCOUNT DISTRIBUTIONS.**

214.14 Subdivision 1. **Qualified distribution methods.** (a) Qualified distributions may  
214.15 be made:

214.16 (1) directly to participating providers of goods and services that are qualified  
214.17 disability expenses, if purchased for a beneficiary;

214.18 (2) in the form of a check payable to both the beneficiary and provider of goods or  
214.19 services that are qualified disability expenses; or

214.20 (3) directly to the beneficiary, if the beneficiary has already paid qualified disability  
214.21 expenses.

214.22 (b) Qualified distributions must be withdrawn proportionally from contributions and  
214.23 earnings in an account owner's account on the date of distribution as provided in section  
214.24 529A of the Internal Revenue Code.

214.25 Subd. 2. **Distributions upon death of a beneficiary.** Upon the death of a  
214.26 beneficiary, the amount remaining in the beneficiary's account must be distributed pursuant  
214.27 to section 529A(f) of the Internal Revenue Code.

214.28 Subd. 3. **Nonqualified distribution.** An account owner may request a nonqualified  
214.29 distribution from an account at any time. Nonqualified distributions are based on the total  
214.30 account balances in an account owner's account and must be withdrawn proportionally  
214.31 from contributions and earnings as provided in section 529A of the Internal Revenue  
214.32 Code. The earnings portion of a nonqualified distribution is subject to a federal additional  
214.33 tax pursuant to section 529A of the Internal Revenue Code. For purposes of this  
214.34 subdivision, "earnings portion" means the ratio of the earnings in the account to the total  
214.35 account balance, immediately prior to the distribution, multiplied by the distribution.

215.1 Sec. 31. Minnesota Statutes 2014, section 282.241, subdivision 1, is amended to read:

215.2 Subdivision 1. **Repurchase requirements.** The owner at the time of forfeiture, or  
215.3 the owner's heirs, devisees, or representatives, or any person to whom the right to pay  
215.4 taxes was given by statute, mortgage, or other agreement, may repurchase any parcel  
215.5 of land claimed by the state to be forfeited to the state for taxes unless before the time  
215.6 repurchase is made the parcel is sold under installment payments, or otherwise, by the  
215.7 state as provided by law, or is under mineral prospecting permit or lease, or proceedings  
215.8 have been commenced by the state or any of its political subdivisions or by the United  
215.9 States to condemn the parcel of land. The parcel of land may be repurchased for the sum  
215.10 of all delinquent taxes and assessments computed under section 282.251, together with  
215.11 penalties, interest, and costs, that accrued or would have accrued if the parcel of land had  
215.12 not forfeited to the state. Except for property which was homesteaded on the date of  
215.13 forfeiture, repurchase is permitted during one year only from the date of forfeiture, and in  
215.14 any case only after the adoption of a resolution by the board of county commissioners  
215.15 determining that by repurchase undue hardship or injustice resulting from the forfeiture  
215.16 will be corrected, or that permitting the repurchase will promote the use of the lands that  
215.17 will best serve the public interest. If the county board has good cause to believe that  
215.18 a repurchase installment payment plan for a particular parcel is unnecessary and not  
215.19 in the public interest, the county board may require as a condition of repurchase that  
215.20 the entire repurchase price be paid at the time of repurchase. A repurchase is subject  
215.21 to any encumbrance allowed under section 256B.15 or 514.981, and to any easement,  
215.22 lease, or other encumbrance granted by the state before the repurchase, and if the land is  
215.23 located within a restricted area established by any county under Laws 1939, chapter 340,  
215.24 the repurchase must not be permitted unless the resolution approving the repurchase is  
215.25 adopted by the unanimous vote of the board of county commissioners.

215.26 The person seeking to repurchase under this section shall pay all maintenance costs  
215.27 incurred by the county auditor during the time the property was tax-forfeited.

215.28 Sec. 32. Minnesota Statutes 2014, section 514.73, is amended to read:

215.29 **514.73 LIENS ASSIGNABLE.**

215.30 Subdivision 1. **Assignment.** All liens given by this chapter or section 256B.15 are  
215.31 assignable and may be asserted and enforced by the assignee, by the assignee's successor or  
215.32 assigns, or by the personal representative of any holder thereof in case of the holder's death.

215.33 Subd. 2. **Redemption.** The redemption rights of all liens given by section 256B.15  
215.34 or sections 514.980 to 514.985 are assignable together with all or a portion of any of the

216.1 claims secured by those liens and may be asserted and enforced by the assignee, or the  
 216.2 assignee's successor or assigns.

216.3 Subd. 3. **Lien payoff information.** The commissioner or a duly authorized agent of  
 216.4 the commissioner may determine and disclose the amount of the outstanding obligation to  
 216.5 be secured by a lien when a lien or redemption right is assigned.

216.6 Sec. 33. Minnesota Statutes 2014, section 514.981, subdivision 2, is amended to read:

216.7 Subd. 2. **Attachment.** (a) A medical assistance lien attaches and becomes  
 216.8 enforceable against specific real property as of the date when the following conditions  
 216.9 are met:

- 216.10 (1) payments have been made by an agency for a medical assistance benefit;
- 216.11 (2) notice and an opportunity for a hearing have been provided under paragraph (b);
- 216.12 (3) a lien notice has been filed as provided in section 514.982;
- 216.13 (4) if the property is registered property, the lien notice has been memorialized on  
 216.14 the certificate of title of the property affected by the lien notice; and
- 216.15 (5) all restrictions against enforcement have ceased to apply.

216.16 (b) An agency may not file a medical assistance lien notice until the medical  
 216.17 assistance recipient or the recipient's legal representative has been sent, by certified or  
 216.18 registered mail, written notice of the agency's lien rights and there has been an opportunity  
 216.19 for a hearing under section 256.045. In addition, the agency may not file a lien notice  
 216.20 unless the agency determines as medically verified by the recipient's attending physician  
 216.21 that the medical assistance recipient cannot reasonably be expected to be discharged from  
 216.22 a medical institution and return home or the medical assistance recipient has resided in a  
 216.23 medical institution for six months or longer.

216.24 (c) An agency may not file a medical assistance lien notice against real property  
 216.25 while it is the home of the recipient's spouse.

216.26 (d) An agency may not file a medical assistance lien notice against real property that  
 216.27 was the homestead of the medical assistance recipient or the recipient's spouse when the  
 216.28 medical assistance recipient received medical institution services if any of the following  
 216.29 persons are lawfully residing in the property:

- 216.30 (1) a child of the medical assistance recipient if the child is under age 21 or is blind or  
 216.31 permanently and totally disabled according to the Supplemental Security Income criteria;
- 216.32 (2) a child of the medical assistance recipient if the child resided in the homestead  
 216.33 for at least two years immediately before the date the medical assistance recipient received  
 216.34 medical institution services, and the child provided care to the medical assistance recipient  
 216.35 that permitted the recipient to live without medical institution services; or



217.1 (3) a sibling of the medical assistance recipient if the sibling has an equity interest in  
217.2 the property and has resided in the property for at least one year immediately before the  
217.3 date the medical assistance recipient began receiving medical institution services.

217.4 (e) A medical assistance lien applies only to the specific real property described in  
217.5 the lien notice.

217.6 Sec. 34. Minnesota Statutes 2014, section 580.032, subdivision 1, is amended to read:

217.7 Subdivision 1. **Recording request for notice.** A person having a redeemable  
217.8 interest in real property under section 580.23 or 580.24, may record a request for notice  
217.9 of a mortgage foreclosure by advertisement with the county recorder or registrar of titles  
217.10 of the county where the property is located. To be effective for purposes of this section,  
217.11 a request for notice must be recorded as a separate and distinct document, except a  
217.12 mechanic's lien statement recorded pursuant to section 514.08 or a lien recorded pursuant  
217.13 to section 256B.15 or 514.981 also constitutes a request for notice if the ~~meehanie's~~ lien  
217.14 statement includes a legal description of the real property and the name and mailing  
217.15 address of the ~~meehanie's~~ lien claimant.

217.16 Sec. 35. **INDIVIDUAL PROVIDERS OF DIRECT SUPPORT SERVICES.**

217.17 The labor agreement between the state of Minnesota and the Service Employees  
217.18 International Union Healthcare Minnesota, submitted to the Legislative Coordinating  
217.19 Commission on March 2, 2015, is ratified.

217.20 **EFFECTIVE DATE.** This section is effective July 1, 2015.

217.21 Sec. 36. **RATE INCREASE FOR DIRECT SUPPORT SERVICES PROVIDERS**  
217.22 **WORKFORCE NEGOTIATIONS.**

217.23 (a) If the labor agreement between the state of Minnesota and the Service Employees  
217.24 International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is  
217.25 approved pursuant to Minnesota Statutes, sections 3.855 and 179A.22, the commissioner  
217.26 of human services shall increase reimbursement rates, individual budgets, grants, or  
217.27 allocations by 1.53 percent for services provided on or after July 1, 2015, and by an  
217.28 additional 0.2 percent for services provided on or after July 1, 2016, to implement the  
217.29 minimum hourly wage and paid time off provisions of that agreement.

217.30 (b) The rate changes described in this section apply to direct support services  
217.31 provided through a covered program, as defined in Minnesota Statutes, section 256B.0711,  
217.32 subdivision 1.

218.1       Sec. 37. **DEVELOPMENT OF LONG-TERM CARE; LIFE STAGE PLANNING**  
218.2 **INSURANCE PRODUCT.**

218.3       The commissioner of human services, in consultation with members of the Own  
218.4 Your Future Advisory Council, the commissioner of commerce, and other stakeholders,  
218.5 shall conduct research on the feasibility of creating a life stage planning insurance  
218.6 product that merges term life insurance with long-term care insurance coverage. The  
218.7 commissioner shall:

218.8           (1) conduct project evaluation research with consumers;

218.9           (2) conduct an actuarial analysis to evaluate likely levels for insurer pricing for the  
218.10 product;

218.11           (3) meet with insurance carriers to determine interest in pursuing the product;

218.12           (4) identify specific state laws and regulations that may need to be amended to  
218.13 make the product available; and

218.14           (5) develop one or more pilot programs to market test the product.

218.15       Sec. 38. **HOME AND COMMUNITY-BASED SERVICES INCENTIVE POOL.**

218.16       The commissioner of human services shall develop an initiative to provide  
218.17 incentives for innovation in achieving integrated competitive employment, living in  
218.18 the most integrated setting, and other outcomes determined by the commissioner. The  
218.19 commissioner shall seek requests for proposals and shall contract with one or more entities  
218.20 to provide incentive payments for meeting identified outcomes. The initial requests for  
218.21 proposals must be issued by October 1, 2015. The commissioner of human services shall  
218.22 submit a report by January 31, 2017, to the chairs and ranking minority members of the  
218.23 legislative committees with jurisdiction over health and human services finance on the  
218.24 outcomes of these projects. The report must include:

218.25           (1) the request for proposals funds;

218.26           (2) the amount of incentive payments authorized;

218.27           (3) the outcomes achieved by each project; and

218.28           (4) recommendations for further action based on the outcomes achieved.

218.29       Sec. 39. **DIRECTION TO COMMISSIONER; REPORTS REQUIRED.**

218.30       The commissioner of human services shall develop and submit reports to the chairs  
218.31 and ranking minority members of the house of representatives and senate committees and  
218.32 divisions with jurisdiction over health and human services policy and finance on the  
218.33 implementation of Minnesota Statutes, sections 256B.0916, subdivisions 2, 11, and 12,

219.1 and 256B.49, subdivisions 26 and 27. The commissioner shall submit two reports, one by  
219.2 February 15, 2018, and the second by February 15, 2019.

219.3 Sec. 40. **DIRECTION TO COMMISSIONER; DAY TRAINING AND**  
219.4 **HABILITATION.**

219.5 For service agreements renewed or entered into on or after January 1, 2016, in  
219.6 determining payments for day training and habilitation under Minnesota Statutes, section  
219.7 256B.4914, subdivision 7, the commissioner of human services shall calculate the  
219.8 transportation portion of the payment for day training and habilitation programs using  
219.9 payments factors found in Minnesota Statutes, section 256B.4914, subdivision 7, clauses  
219.10 (16) and (17).

219.11 **ARTICLE 7**

219.12 **HEALTH DEPARTMENT**

219.13 Section 1. Minnesota Statutes 2014, section 13.3806, subdivision 4, is amended to read:

219.14 Subd. 4. **Vital statistics. (a) Parents' Social Security number; birth record.**

219.15 Parents' Social Security numbers and certain contact information provided for a child's  
219.16 birth record are classified under section 144.215, subdivision 4, or 4a.

219.17 (b) **Foundling registration.** The report of the finding of an infant of unknown  
219.18 parentage is classified under section 144.216, subdivision 2.

219.19 (c) **New record of birth.** In circumstances in which a new record of birth may  
219.20 be issued under section 144.218, the original record of birth is classified as provided  
219.21 in that section.

219.22 (d) **Vital records.** Physical access to vital records is governed by section 144.225,  
219.23 subdivision 1.

219.24 (e) **Birth record of child of unmarried parents.** Access to the birth record of a  
219.25 child whose parents were not married to each other when the child was conceived or born  
219.26 is governed by sections 144.225, subdivisions 2 and 4, and 257.73.

219.27 (f) **Health data for birth registration.** Health data collected for birth registration or  
219.28 fetal death reporting are classified under section 144.225, subdivision 2a.

219.29 (g) **Birth record; sharing.** Sharing of birth record data and data prepared under  
219.30 section 257.75, is governed by section 144.225, subdivision 2b.

219.31 (h) **Group purchaser identity for birth registration.** Classification of and access  
219.32 to the identity of a group purchaser collected in association with birth registration is  
219.33 governed by section 144.225, subdivision 6.

220.1       Sec. 2. **[15.445] RETAIL FOOD ESTABLISHMENT FEES.**

220.2           Subdivision 1. Fees. The fees in this section are required for food and beverage  
220.3 service establishments licensed under chapter 157. Food and beverage service  
220.4 establishments must pay the applicable fee under subdivision 2, paragraph (a), (b), (c),  
220.5 or (d), and all applicable fees under subdivision 4. Temporary food establishments and  
220.6 special events must pay the applicable fee under subdivision 3.

220.7           Subd. 2. Permanent food establishments. (a) The Category 1 establishment  
220.8 license fee is \$210 annually. "Category 1 establishment" means an establishment that  
220.9 does one or more of the following:

220.10           (1) sells only prepackaged nonpotentially hazardous foods as defined in Minnesota  
220.11 Rules, chapter 4626;

220.12           (2) provides cleaning for eating, drinking, or cooking utensils, when the only food  
220.13 served is prepared off-site; or

220.14           (3) operates a childcare facility licensed under section 245A.03 and Minnesota  
220.15 Rules, chapter 9503.

220.16           (b) The Category 2 establishment license fee is \$270 annually. "Category 2  
220.17 establishment" means an establishment that is not a Category 1 establishment and is either:

220.18           (1) a food establishment where the method of food preparation meets the definition  
220.19 of a low-risk establishment in section 157.20; or

220.20           (2) an elementary or secondary school as defined in section 120A.05.

220.21           (c) The Category 3 establishment license fee is \$460 annually. "Category 3  
220.22 establishment" means an establishment that is not a Category 1 or 2 establishment and  
220.23 the method of food preparation meets the definition of a medium-risk establishment in  
220.24 section 157.20.

220.25           (d) The Category 4 establishment license fee is \$690 annually. "Category 4  
220.26 establishment" means an establishment that is not a Category 1, 2, or 3 establishment  
220.27 and is either:

220.28           (1) a food establishment where the method of food preparation meets the definition  
220.29 of a high-risk establishment in section 157.20; or

220.30           (2) an establishment where 500 or more meals per day are prepared at one location  
220.31 and served at one or more separate locations.

220.32           Subd. 3. Temporary food establishments and special events. (a) The special  
220.33 event food stand license fee is \$50 annually. Special event food stand is where food is  
220.34 prepared or served in conjunction with celebrations, county fairs, or special events from a  
220.35 special event food stand as defined in section 157.15.

221.1 (b) The temporary food and beverage service license fee is \$210 annually. A  
 221.2 temporary food and beverage service includes food carts, mobile food units, seasonal  
 221.3 temporary food stands, retail food vehicles, portable structures, and seasonal permanent  
 221.4 food stands.

221.5 Subd. 4. **Additional applicable fees.** (a) The individual private sewer or individual  
 221.6 private water license fee is \$60 annually. Individual private water is a water supply other  
 221.7 than a community public water supply as covered in Minnesota Rules, chapter 4720.  
 221.8 Individual private sewer is an individual sewage treatment system which uses subsurface  
 221.9 treatment and disposal.

221.10 (b) The additional food or beverage service license fee is \$165 annually. Additional  
 221.11 food or beverage service is a location at a food service establishment, other than the  
 221.12 primary food preparation and service area, used to prepare or serve food or beverages to  
 221.13 the public. Additional food service does not apply to school concession stands.

221.14 (c) The specialized processing license fee is \$400 annually. Specialized processing  
 221.15 is a business that performs one or more specialized processes that require a HACCP as  
 221.16 required in Minnesota Rules, chapter 4626.

221.17 Sec. 3. Minnesota Statutes 2014, section 16A.724, subdivision 2, is amended to read:

221.18 Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available  
 221.19 resources in the health care access fund exceed expenditures in that fund, effective for  
 221.20 the biennium beginning July 1, 2007, the commissioner of management and budget shall  
 221.21 transfer the excess funds from the health care access fund to the general fund on June 30  
 221.22 of each year, provided that the amount transferred in any fiscal biennium shall not exceed  
 221.23 \$96,000,000. The purpose of this transfer is to meet the rate increase required under Laws  
 221.24 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6.

221.25 (b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and,  
 221.26 if necessary, the commissioner shall reduce these transfers from the health care access  
 221.27 fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary,  
 221.28 transfer sufficient funds from the general fund to the health care access fund to meet  
 221.29 annual MinnesotaCare expenditures.

221.30 ~~(c) Notwithstanding section 295.581, to the extent available resources in the health~~  
 221.31 ~~care access fund exceed expenditures in that fund after the transfer required in paragraph~~  
 221.32 ~~(a), effective for the biennium beginning July 1, 2013, the commissioner of management~~  
 221.33 ~~and budget shall transfer \$1,000,000 each fiscal year from the health access fund to~~  
 221.34 ~~the medical education and research costs fund established under section 62J.692, for~~  
 221.35 ~~distribution under section 62J.692, subdivision 4, paragraph (c).~~

222.1 Sec. 4. Minnesota Statutes 2014, section 62J.498, is amended to read:

222.2 **62J.498 HEALTH INFORMATION EXCHANGE.**

222.3 Subdivision 1. **Definitions.** The following definitions apply to sections 62J.498 to  
222.4 62J.4982:

222.5 (a) "Clinical data repository" means a real time database that consolidates data from  
222.6 a variety of clinical sources to present a unified view of a single patient and is used by a  
222.7 state-certified health information exchange service provider to enable health information  
222.8 exchange among health care providers that are not related health care entities as defined in  
222.9 section 144.291, subdivision 2, paragraph (j). This does not include clinical data that are  
222.10 submitted to the commissioner for public health purposes required or permitted by law,  
222.11 including any rules adopted by the commissioner.

222.12 ~~(a)~~ (b) "Clinical transaction" means any meaningful use transaction or other health  
222.13 information exchange transaction that is not covered by section 62J.536.

222.14 ~~(b)~~ (c) "Commissioner" means the commissioner of health.

222.15 ~~(e) "Direct health information exchange" means the electronic transmission of~~  
222.16 ~~health-related information through a direct connection between the electronic health~~  
222.17 ~~record systems of health care providers without the use of a health data intermediary.~~

222.18 (d) "Health care provider" or "provider" means a health care provider or provider as  
222.19 defined in section 62J.03, subdivision 8.

222.20 (e) "Health data intermediary" means an entity that provides the ~~infrastructure~~  
222.21 technical capabilities or related products and services to connect computer systems or  
222.22 ~~other electronic devices used by health care providers, laboratories, pharmacies, health~~  
222.23 ~~plans, third-party administrators, or pharmacy benefit managers to facilitate the secure~~  
222.24 ~~transmission of health information, including~~ enable health information exchange among  
222.25 health care providers that are not related health care entities as defined in section 144.291,  
222.26 subdivision 2, paragraph (j). This includes but is not limited to: health information service  
222.27 providers (HISP), electronic health record vendors, and pharmaceutical electronic data  
222.28 ~~intermediaries as defined in section 62J.495. This does not include health care providers~~  
222.29 ~~engaged in direct health information exchange.~~

222.30 (f) "Health information exchange" means the electronic transmission of health-related  
222.31 information between organizations according to nationally recognized standards.

222.32 (g) "Health information exchange service provider" means a health data intermediary  
222.33 or health information organization ~~that has been issued a certificate of authority by the~~  
222.34 ~~commissioner under section 62J.4981.~~

222.35 (h) "Health information organization" means an organization that oversees, governs,  
222.36 and facilitates the health information exchange ~~of health-related information~~ among

223.1 ~~organizations according to nationally recognized standards~~ health care providers that are  
 223.2 not related health care entities as defined in section 144.291, subdivision 2, paragraph (j),  
 223.3 to improve coordination of patient care and the efficiency of health care delivery.

223.4 (i) "HITECH Act" means the Health Information Technology for Economic and  
 223.5 Clinical Health Act as defined in section 62J.495.

223.6 (j) "Major participating entity" means:

223.7 (1) a participating entity that receives compensation for services that is greater  
 223.8 than 30 percent of the health information organization's gross annual revenues from the  
 223.9 health information exchange service provider;

223.10 (2) a participating entity providing administrative, financial, or management services  
 223.11 to the health information organization, if the total payment for all services provided by the  
 223.12 participating entity exceeds three percent of the gross revenue of the health information  
 223.13 organization; and

223.14 (3) a participating entity that nominates or appoints 30 percent or more of the board  
 223.15 of directors or equivalent governing body of the health information organization.

223.16 (k) "Master patient index" means an electronic database that holds unique identifiers  
 223.17 of patients registered at a care facility and is used by a state-certified health information  
 223.18 exchange service provider to enable health information exchange among health care  
 223.19 providers that are not related health care entities as defined in section 144.291, subdivision  
 223.20 2, paragraph (j). This does not include data that are submitted to the commissioner for  
 223.21 public health purposes required or permitted by law, including any rules adopted by the  
 223.22 commissioner.

223.23 ~~(l)~~ (l) "Meaningful use" means use of certified electronic health record technology  
 223.24 ~~that includes e-prescribing, and is connected in a manner that provides for the electronic~~  
 223.25 ~~exchange of health information and used for the submission of clinical quality measures~~  
 223.26 to improve quality, safety, and efficiency and reduce health disparities; engage patients  
 223.27 and families; improve care coordination and population and public health; and maintain  
 223.28 privacy and security of patient health information as established by the Center for  
 223.29 Medicare and Medicaid Services and the Minnesota Department of Human Services  
 223.30 pursuant to sections 4101, 4102, and 4201 of the HITECH Act.

223.31 ~~(m)~~ (m) "Meaningful use transaction" means an electronic transaction that a health  
 223.32 care provider must exchange to receive Medicare or Medicaid incentives or avoid  
 223.33 Medicare penalties pursuant to sections 4101, 4102, and 4201 of the HITECH Act.

223.34 ~~(n)~~ (n) "Participating entity" means any of the following persons, health care  
 223.35 providers, companies, or other organizations with which a health information organization

224.1 or health data intermediary has contracts or other agreements for the provision of health  
 224.2 information exchange ~~service providers~~ services:

224.3 (1) a health care facility licensed under sections 144.50 to 144.56, a nursing home  
 224.4 licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise  
 224.5 licensed under the laws of this state or registered with the commissioner;

224.6 (2) a health care provider, and any other health care professional otherwise licensed  
 224.7 under the laws of this state or registered with the commissioner;

224.8 (3) a group, professional corporation, or other organization that provides the  
 224.9 services of individuals or entities identified in clause (2), including but not limited to a  
 224.10 medical clinic, a medical group, a home health care agency, an urgent care center, and  
 224.11 an emergent care center;

224.12 (4) a health plan as defined in section 62A.011, subdivision 3; and

224.13 (5) a state agency as defined in section 13.02, subdivision 17.

224.14 ~~(n)~~ (o) "Reciprocal agreement" means an arrangement in which two or more health  
 224.15 information exchange service providers agree to share in-kind services and resources to  
 224.16 allow for the pass-through of meaningful-use clinical transactions.

224.17 ~~(o)~~ (p) "State-certified health data intermediary" means a health data intermediary  
 224.18 that ~~has been issued a certificate of authority to operate in Minnesota.~~

224.19 ~~(1) provides a subset of the meaningful use transaction capabilities necessary for~~  
 224.20 ~~hospitals and providers to achieve meaningful use of electronic health records;~~

224.21 ~~(2) is not exclusively engaged in the exchange of meaningful use transactions~~  
 224.22 ~~covered by section 62J.536; and~~

224.23 ~~(3) has been issued a certificate of authority to operate in Minnesota.~~

224.24 ~~(p)~~ (q) "State-certified health information organization" means a ~~nonprofit~~ health  
 224.25 information organization that ~~provides transaction capabilities necessary to fully support~~  
 224.26 ~~clinical transactions required for meaningful use of electronic health records that has been~~  
 224.27 ~~issued a certificate of authority to operate in Minnesota.~~

224.28 Subd. 2. **Health information exchange oversight.** (a) The commissioner shall  
 224.29 protect the public interest on matters pertaining to health information exchange. The  
 224.30 commissioner shall:

224.31 (1) review and act on applications from health data intermediaries and health  
 224.32 information organizations for certificates of authority to operate in Minnesota;

224.33 (2) provide ongoing monitoring to ensure compliance with criteria established under  
 224.34 sections 62J.498 to 62J.4982;

224.35 (3) respond to public complaints related to health information exchange services;



225.1 (4) take enforcement actions as necessary, including the imposition of fines,  
225.2 suspension, or revocation of certificates of authority as outlined in section 62J.4982;

225.3 (5) provide a biennial report on the status of health information exchange services  
225.4 that includes but is not limited to:

225.5 (i) recommendations on actions necessary to ensure that health information exchange  
225.6 services are adequate to meet the needs of Minnesota citizens and providers statewide;

225.7 (ii) recommendations on enforcement actions to ensure that health information  
225.8 exchange service providers act in the public interest without causing disruption in health  
225.9 information exchange services;

225.10 (iii) recommendations on updates to criteria for obtaining certificates of authority  
225.11 under this section; and

225.12 (iv) recommendations on standard operating procedures for health information  
225.13 exchange, including but not limited to the management of consumer preferences; and

225.14 (6) other duties necessary to protect the public interest.

225.15 (b) As part of the application review process for certification under paragraph (a),  
225.16 prior to issuing a certificate of authority, the commissioner shall:

225.17 (1) ~~hold public hearings that provide an adequate opportunity for participating~~  
225.18 ~~entities and consumers to provide feedback and recommendations on the application under~~  
225.19 ~~consideration. The commissioner shall make all portions of the application classified as~~  
225.20 ~~public data available to the public for at least ten days in advance of the hearing while~~  
225.21 an application is under consideration. At the request of the commissioner, the applicant  
225.22 shall participate in the a public hearing by presenting an overview of their application and  
225.23 responding to questions from interested parties; and

225.24 (2) ~~make available all feedback and recommendations gathered at the hearing~~  
225.25 ~~available to the public prior to issuing a certificate of authority; and~~

225.26 (3) ~~consult with hospitals, physicians, and other professionals eligible to receive~~  
225.27 ~~meaningful use incentive payments or subject to penalties as established in the HITECH~~  
225.28 ~~Act, and their respective statewide associations, providers prior to issuing a certificate of~~  
225.29 ~~authority.~~

225.30 (c) When the commissioner is actively considering a suspension or revocation of a  
225.31 certificate of authority as described in section 62J.4982, subdivision 3, all investigatory  
225.32 data that are collected, created, or maintained related to the suspension or revocation  
225.33 are classified as confidential data on individuals and as protected nonpublic data in the  
225.34 case of data not on individuals.

226.1 (d) The commissioner may disclose data classified as protected nonpublic or  
 226.2 confidential under paragraph (c) if disclosing the data will protect the health or safety of  
 226.3 patients.

226.4 (e) After the commissioner makes a final determination regarding a suspension or  
 226.5 revocation of a certificate of authority, all minutes, orders for hearing, findings of fact,  
 226.6 conclusions of law, and the specification of the final disciplinary action, are classified  
 226.7 as public data.

226.8 Sec. 5. Minnesota Statutes 2014, section 62J.4981, is amended to read:

226.9 **62J.4981 CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH**  
 226.10 **INFORMATION EXCHANGE SERVICES.**

226.11 Subdivision 1. **Authority to require organizations to apply.** The commissioner  
 226.12 shall require ~~an entity providing health information exchange services~~ a health data  
 226.13 intermediary or a health information organization to apply for a certificate of authority  
 226.14 under this section. An applicant may continue to operate until the commissioner acts  
 226.15 on the application. If the application is denied, the applicant is considered a health  
 226.16 information ~~organization~~ exchange service provider whose certificate of authority has  
 226.17 been revoked under section 62J.4982, subdivision 2, paragraph (d).

226.18 Subd. 2. **Certificate of authority for health data intermediaries.** (a) A health  
 226.19 data intermediary ~~that provides health information exchange services for the transmission~~  
 226.20 ~~of one or more clinical transactions necessary for hospitals, providers, or eligible~~  
 226.21 ~~professionals to achieve meaningful use~~ must be ~~registered with~~ certified by the state and  
 226.22 comply with requirements established in this section.

226.23 (b) Notwithstanding any law to the contrary, any corporation organized to do so  
 226.24 may apply to the commissioner for a certificate of authority to establish and operate as  
 226.25 a health data intermediary in compliance with this section. No person shall establish or  
 226.26 operate a health data intermediary in this state, nor sell or offer to sell, or solicit offers  
 226.27 to purchase or receive advance or periodic consideration in conjunction with a health  
 226.28 data intermediary contract unless the organization has a certificate of authority or has an  
 226.29 application under active consideration under this section.

226.30 (c) In issuing the certificate of authority, the commissioner shall determine whether  
 226.31 the applicant for the certificate of authority has demonstrated that the applicant meets  
 226.32 the following minimum criteria:

226.33 ~~(1) interoperate with at least one state-certified health information organization;~~

226.34 ~~(2) provide an option for Minnesota entities to connect to their services through at~~  
 226.35 ~~least one state-certified health information organization;~~

227.1 ~~(3) have a record locator service as defined in section 144.291, subdivision 2,~~  
 227.2 ~~paragraph (i), that is compliant with the requirements of section 144.293, subdivision 8,~~  
 227.3 ~~when conducting meaningful use transactions; and~~

227.4 ~~(4) (1) hold reciprocal agreements with at least one state-certified health information~~  
 227.5 ~~organization to enable access to record locator services to find patient data, and for the~~  
 227.6 ~~transmission and receipt of meaningful use clinical transactions consistent with the~~  
 227.7 ~~format and content required by national standards established by Centers for Medicare~~  
 227.8 ~~and Medicaid Services. Reciprocal agreements must meet the requirements established in~~  
 227.9 ~~subdivision 5.; and~~

227.10 ~~(2) participate in statewide shared health information exchange services as defined~~  
 227.11 ~~by the commissioner to support interoperability between state-certified health information~~  
 227.12 ~~organizations and state-certified health data intermediaries.~~

227.13 **Subd. 3. Certificate of authority for health information organizations.**

227.14 ~~(a) A health information organization that provides all electronic capabilities for the~~  
 227.15 ~~transmission of clinical transactions necessary for meaningful use of electronic health~~  
 227.16 ~~records must obtain a certificate of authority from the commissioner and demonstrate~~  
 227.17 ~~compliance with the criteria in paragraph (c).~~

227.18 ~~(b) Notwithstanding any law to the contrary, a nonprofit corporation organized to~~  
 227.19 ~~do so an organization may apply for a certificate of authority to establish and operate a~~  
 227.20 ~~health information organization under this section. No person shall establish or operate a~~  
 227.21 ~~health information organization in this state, nor sell or offer to sell, or solicit offers~~  
 227.22 ~~to purchase or receive advance or periodic consideration in conjunction with a health~~  
 227.23 ~~information organization or health information contract unless the organization has a~~  
 227.24 ~~certificate of authority under this section.~~

227.25 ~~(c) In issuing the certificate of authority, the commissioner shall determine whether~~  
 227.26 ~~the applicant for the certificate of authority has demonstrated that the applicant meets~~  
 227.27 ~~the following minimum criteria:~~

227.28 ~~(1) the entity is a legally established, nonprofit organization;~~

227.29 ~~(2) appropriate insurance, including liability insurance, for the operation of the~~  
 227.30 ~~health information organization is in place and sufficient to protect the interest of the~~  
 227.31 ~~public and participating entities;~~

227.32 ~~(3) strategic and operational plans clearly address governance, technical~~  
 227.33 ~~infrastructure, legal and policy issues, finance, and business operations in regard to how~~  
 227.34 ~~the organization will expand technical capacity of the health information organization~~  
 227.35 ~~to support providers in achieving meaningful use of electronic health records health~~  
 227.36 ~~information exchange goals over time;~~

228.1 (4) the entity addresses the parameters to be used with participating entities and  
228.2 other health information ~~organizations~~ exchange service providers for ~~meaningful use~~  
228.3 clinical transactions, compliance with Minnesota law, and interstate health information  
228.4 exchange ~~in~~ trust agreements;

228.5 (5) the entity's board of directors or equivalent governing body is composed of  
228.6 members that broadly represent the health information organization's participating entities  
228.7 and consumers;

228.8 (6) the entity maintains a professional staff responsible to the board of directors or  
228.9 equivalent governing body with the capacity to ensure accountability to the organization's  
228.10 mission;

228.11 (7) the organization is compliant with ~~criteria established under the Health~~  
228.12 ~~Information Exchange Accreditation Program of the Electronic Healthcare Network~~  
228.13 ~~Accreditation Commission (EHNAC) or equivalent criteria established~~ national  
228.14 certification and accreditation programs designated by the commissioner;

228.15 (8) the entity maintains a the capability to query for patient information based on  
228.16 national standards. The query capability may utilize a master patient index, clinical  
228.17 data repository, or record locator service as defined in section 144.291, subdivision 2,  
228.18 paragraph (i), that is. The entity must be compliant with the requirements of section  
228.19 144.293, subdivision 8, when conducting ~~meaningful use~~ clinical transactions;

228.20 (9) the organization demonstrates interoperability with all other state-certified health  
228.21 information organizations using nationally recognized standards;

228.22 (10) the organization demonstrates compliance with all privacy and security  
228.23 requirements required by state and federal law; and

228.24 (11) the organization uses financial policies and procedures consistent with generally  
228.25 accepted accounting principles and has an independent audit of the organization's  
228.26 financials on an annual basis.

228.27 (d) Health information organizations that have obtained a certificate of authority must:

228.28 (1) meet the requirements established for connecting to the ~~Nationwide Health~~  
228.29 ~~Information Network (NHIN) within the federally mandated timeline or within a time~~  
228.30 ~~frame established by the commissioner and published in the State Register. If the state~~  
228.31 ~~timeline for implementation varies from the federal timeline, the State Register notice~~  
228.32 ~~shall include an explanation for the variation~~ National eHealth Exchange;

228.33 (2) annually submit strategic and operational plans for review by the commissioner  
228.34 that address:

228.35 (i) ~~increasing adoption rates to include a sufficient number of participating entities to~~  
228.36 ~~achieve financial sustainability; and~~

229.1           ~~(ii)~~ (i) progress in achieving objectives included in previously submitted strategic  
229.2 and operational plans across the following domains: business and technical operations,  
229.3 technical infrastructure, legal and policy issues, finance, and organizational governance;  
229.4           ~~(3) develop and maintain a business plan that addresses:~~  
229.5           ~~(i)~~ (ii) plans for ensuring the necessary capacity to support meaningful use clinical  
229.6 transactions;  
229.7           ~~(ii)~~ (iii) approach for attaining financial sustainability, including public and private  
229.8 financing strategies, and rate structures;  
229.9           ~~(iii)~~ (iv) rates of adoption, utilization, and transaction volume, and mechanisms to  
229.10 support health information exchange; and  
229.11           ~~(iv)~~ (v) an explanation of methods employed to address the needs of community  
229.12 clinics, critical access hospitals, and free clinics in accessing health information exchange  
229.13 services;  
229.14           ~~(4) annually submit a rate plan to the commissioner outlining fee structures for health~~  
229.15 ~~information exchange services for approval by the commissioner. The commissioner~~  
229.16 ~~shall approve the rate plan if it:~~  
229.17           ~~(i) distributes costs equitably among users of health information services;~~  
229.18           ~~(ii) provides predictable costs for participating entities;~~  
229.19           ~~(iii) covers all costs associated with conducting the full range of meaningful use~~  
229.20 ~~clinical transactions, including access to health information retrieved through other~~  
229.21 ~~state-certified health information exchange service providers; and~~  
229.22           ~~(iv) provides for a predictable revenue stream for the health information organization~~  
229.23 ~~and generates sufficient resources to maintain operating costs and develop technical~~  
229.24 ~~infrastructure necessary to serve the public interest;~~  
229.25           ~~(5)~~ (3) enter into reciprocal agreements with all other state-certified health  
229.26 information organizations and state-certified health data intermediaries to enable access  
229.27 to ~~record locator services to find patient data, and for the~~ transmission and receipt of  
229.28 meaningful use clinical transactions consistent with the format and content required by  
229.29 national standards established by Centers for Medicare and Medicaid Services. Reciprocal  
229.30 agreements must meet the requirements in subdivision 5; and  
229.31           ~~(4)~~ (4) participate in statewide shared health information exchange services as defined  
229.32 by the commissioner to support interoperability between state-certified health information  
229.33 organizations and state-certified health data intermediaries; and  
229.34           ~~(6)~~ (5) comply with additional requirements for the certification or recertification of  
229.35 health information organizations that may be established by the commissioner.

230.1 Subd. 4. **Application for certificate of authority for health information exchange**  
 230.2 **service providers.** (a) Each application for a certificate of authority shall be in a form  
 230.3 prescribed by the commissioner and verified by an officer or authorized representative  
 230.4 of the applicant. Each application shall include the following in addition to information  
 230.5 described in the criteria in subdivisions 2 and 3:

230.6 (1) for health information organizations only, a copy of the basic organizational  
 230.7 document, if any, of the applicant and of each major participating entity, such as the  
 230.8 articles of incorporation, or other applicable documents, and all amendments to it;

230.9 (2) for health information organizations only, a list of the names, addresses, and  
 230.10 official positions of the following:

230.11 (i) all members of the board of directors or equivalent governing body, and the  
 230.12 principal officers and, if applicable, shareholders of the applicant organization; and

230.13 (ii) all members of the board of directors or equivalent governing body, and the  
 230.14 principal officers of each major participating entity and, if applicable, each shareholder  
 230.15 beneficially owning more than ten percent of any voting stock of the major participating  
 230.16 entity;

230.17 (3) for health information organizations only, the name and address of each  
 230.18 participating entity and the agreed-upon duration of each contract or agreement if  
 230.19 applicable;

230.20 (4) a copy of each standard agreement or contract intended to bind the participating  
 230.21 entities and the health information ~~organization~~ exchange service provider. Contractual  
 230.22 provisions shall be consistent with the purposes of this section, in regard to the services to  
 230.23 be performed under the standard agreement or contract, the manner in which payment for  
 230.24 services is determined, the nature and extent of responsibilities to be retained by the health  
 230.25 information organization, and contractual termination provisions;

230.26 ~~(5) a copy of each contract intended to bind major participating entities and the~~  
 230.27 ~~health information organization. Contract information filed with the commissioner under~~  
 230.28 ~~this section shall be nonpublic as defined in section 13.02, subdivision 9;~~

230.29 ~~(6)~~ (5) a statement generally describing the health information ~~organization~~ exchange  
 230.30 service provider, its health information exchange contracts, facilities, and personnel,  
 230.31 including a statement describing the manner in which the applicant proposes to provide  
 230.32 participants with comprehensive health information exchange services;

230.33 ~~(7) financial statements showing the applicant's assets, liabilities, and sources~~  
 230.34 ~~of financial support, including a copy of the applicant's most recent certified financial~~  
 230.35 ~~statement;~~

231.1 ~~(8) strategic and operational plans that specifically address how the organization~~  
 231.2 ~~will expand technical capacity of the health information organization to support providers~~  
 231.3 ~~in achieving meaningful use of electronic health records over time, a description of~~  
 231.4 ~~the proposed method of marketing the services, a schedule of proposed charges, and a~~  
 231.5 ~~financial plan that includes a three-year projection of the expenses and income and other~~  
 231.6 ~~sources of future capital;~~

231.7 ~~(9)~~ (6) a statement reasonably describing the geographic area or areas to be served  
 231.8 and the type or types of participants to be served;

231.9 ~~(10)~~ (7) a description of the complaint procedures to be used as required under  
 231.10 this section;

231.11 ~~(11)~~ (8) a description of the mechanism by which participating entities will have an  
 231.12 opportunity to participate in matters of policy and operation;

231.13 ~~(12)~~ (9) a copy of any pertinent agreements between the health information  
 231.14 organization and insurers, including liability insurers, demonstrating coverage is in place;

231.15 ~~(13)~~ (10) a copy of the conflict of interest policy that applies to all members of the  
 231.16 board of directors or equivalent governing body and the principal officers of the health  
 231.17 information organization; and

231.18 ~~(14)~~ (11) other information as the commissioner may reasonably require to be  
 231.19 provided.

231.20 (b) Within ~~30~~ 45 days after the receipt of the application for a certificate of authority,  
 231.21 the commissioner shall determine whether or not the application submitted meets the  
 231.22 requirements for completion in paragraph (a), and notify the applicant of any further  
 231.23 information required for the application to be processed.

231.24 (c) Within 90 days after the receipt of a complete application for a certificate of  
 231.25 authority, the commissioner shall issue a certificate of authority to the applicant if the  
 231.26 commissioner determines that the applicant meets the minimum criteria requirements  
 231.27 of subdivision 2 for health data intermediaries or subdivision 3 for health information  
 231.28 organizations. If the commissioner determines that the applicant is not qualified, the  
 231.29 commissioner shall notify the applicant and specify the reasons for disqualification.

231.30 (d) Upon being granted a certificate of authority to operate as a state-certified health  
 231.31 information organization or state-certified health data intermediary, the organization must  
 231.32 operate in compliance with the provisions of this section. Noncompliance may result in  
 231.33 the imposition of a fine or the suspension or revocation of the certificate of authority  
 231.34 according to section 62J.4982.

231.35 **Subd. 5. Reciprocal agreements between health information exchange entities.**

231.36 (a) Reciprocal agreements between two health information organizations or between a

232.1 health information organization and a health data intermediary must include a fair and  
 232.2 equitable model for charges between the entities that:

232.3 (1) does not impede the secure transmission of clinical transactions necessary to  
 232.4 achieve meaningful use;

232.5 (2) does not charge a fee for the exchange of meaningful use transactions transmitted  
 232.6 according to nationally recognized standards where no additional value-added service  
 232.7 is rendered to the sending or receiving health information organization or health data  
 232.8 intermediary either directly or on behalf of the client;

232.9 (3) is consistent with fair market value and proportionately reflects the value-added  
 232.10 services accessed as a result of the agreement; and

232.11 (4) prevents health care stakeholders from being charged multiple times for the  
 232.12 same service.

232.13 (b) Reciprocal agreements must include comparable quality of service standards that  
 232.14 ensure equitable levels of services.

232.15 (c) Reciprocal agreements are subject to review and approval by the commissioner.

232.16 (d) Nothing in this section precludes a state-certified health information organization  
 232.17 or state-certified health data intermediary from entering into contractual agreements for  
 232.18 the provision of value-added services beyond meaningful use transactions.

232.19 ~~(e) The commissioner of human services or health, when providing access to data or~~  
 232.20 ~~services through a certified health information organization, must offer the same data or~~  
 232.21 ~~services directly through any certified health information organization at the same pricing,~~  
 232.22 ~~if the health information organization pays for all connection costs to the state data or~~  
 232.23 ~~service. For all external connectivity to the respective agencies through existing or future~~  
 232.24 ~~information exchange implementations, the respective agency shall establish the required~~  
 232.25 ~~connectivity methods as well as protocol standards to be utilized.~~

232.26 ~~Subd. 6. **State participation in health information exchange.** A state agency that~~  
 232.27 ~~connects to a health information exchange service provider for the purpose of exchanging~~  
 232.28 ~~meaningful use transactions must ensure that the contracted health information exchange~~  
 232.29 ~~service provider has reciprocal agreements in place as required by this section. The~~  
 232.30 ~~reciprocal agreements must provide equal access to information supplied by the agency as~~  
 232.31 ~~necessary for meaningful use by the participating entities of the other health information~~  
 232.32 ~~service providers.~~

232.33 Sec. 6. Minnesota Statutes 2014, section 62J.4982, subdivision 4, is amended to read:

232.34 Subd. 4. **Coordination.** (a) The commissioner shall, to the extent possible, seek  
 232.35 the advice of the Minnesota e-Health Advisory Committee, in the review and update of



233.1 criteria for the certification and recertification of health information exchange service  
 233.2 providers when implementing sections 62J.498 to 62J.4982.

233.3 ~~(b) By January 1, 2011, the commissioner shall report to the governor and the chairs~~  
 233.4 ~~of the senate and house of representatives committees having jurisdiction over health~~  
 233.5 ~~information policy issues on the status of health information exchange in Minnesota, and~~  
 233.6 ~~provide recommendations on further action necessary to facilitate the secure electronic~~  
 233.7 ~~movement of health information among health providers that will enable Minnesota~~  
 233.8 ~~providers and hospitals to meet meaningful use exchange requirements.~~

233.9 Sec. 7. Minnesota Statutes 2014, section 62J.4982, subdivision 5, is amended to read:

233.10 Subd. 5. **Fees and monetary penalties.** (a) The commissioner shall assess fees  
 233.11 on every health information exchange service provider subject to sections 62J.4981 and  
 233.12 62J.4982 as follows:

233.13 (1) filing an application for certificate of authority to operate as a health information  
 233.14 organization, ~~\$10,500~~ \$7,000;

233.15 (2) filing an application for certificate of authority to operate as a health data  
 233.16 intermediary, \$7,000;

233.17 (3) annual health information organization certificate fee, ~~\$14,000~~ \$7,000; and

233.18 (4) annual health data intermediary certificate fee, \$7,000; ~~and~~

233.19 ~~(5) fees for other filings, as specified by rule.~~

233.20 (b) Fees collected under this section shall be deposited in the state treasury and  
 233.21 credited to the state government special revenue fund.

233.22 ~~(b)~~ (c) Administrative monetary penalties imposed under this subdivision shall  
 233.23 be credited to an account in the special revenue fund and are appropriated to the  
 233.24 commissioner for the purposes of sections 62J.498 to 62J.4982.

233.25 Sec. 8. Minnesota Statutes 2014, section 62J.692, subdivision 4, is amended to read:

233.26 Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute the  
 233.27 available medical education funds to all qualifying applicants based on a public program  
 233.28 volume factor, which is determined by the total volume of public program revenue  
 233.29 received by each training site as a percentage of all public program revenue received by  
 233.30 all training sites in the fund pool.

233.31 Public program revenue for the distribution formula includes revenue from medical  
 233.32 assistance, prepaid medical assistance, general assistance medical care, and prepaid  
 233.33 general assistance medical care. Training sites that receive no public program revenue  
 233.34 are ineligible for funds available under this subdivision. For purposes of determining

234.1 training-site level grants to be distributed under this paragraph, total statewide average  
234.2 costs per trainee for medical residents is based on audited clinical training costs per trainee  
234.3 in primary care clinical medical education programs for medical residents. Total statewide  
234.4 average costs per trainee for dental residents is based on audited clinical training costs  
234.5 per trainee in clinical medical education programs for dental students. Total statewide  
234.6 average costs per trainee for pharmacy residents is based on audited clinical training  
234.7 costs per trainee in clinical medical education programs for pharmacy students. Training  
234.8 sites whose training site level grant is less than \$5,000, based on the formula described  
234.9 in this paragraph, or that train fewer than 0.1 FTE eligible trainees, are ineligible for  
234.10 funds available under this subdivision. No training sites shall receive a grant per FTE  
234.11 trainee that is in excess of the 95th percentile grant per FTE across all eligible training  
234.12 sites; grants in excess of this amount will be redistributed to other eligible sites based on  
234.13 the formula described in this paragraph.

234.14 (b) For funds distributed in fiscal years 2014 and 2015, the distribution formula shall  
234.15 include a supplemental public program volume factor, which is determined by providing  
234.16 a supplemental payment to training sites whose public program revenue accounted for  
234.17 at least 0.98 percent of the total public program revenue received by all eligible training  
234.18 sites. The supplemental public program volume factor shall be equal to ten percent of each  
234.19 training site's grant for funds distributed in fiscal year 2014 and for funds distributed in  
234.20 fiscal year 2015. Grants to training sites whose public program revenue accounted for less  
234.21 than 0.98 percent of the total public program revenue received by all eligible training sites  
234.22 shall be reduced by an amount equal to the total value of the supplemental payment. For  
234.23 fiscal year 2016 and beyond, the distribution of funds shall be based solely on the public  
234.24 program volume factor as described in paragraph (a).

234.25 ~~(c) Of available medical education funds, \$1,000,000 shall be distributed each~~  
234.26 ~~year for grants to family medicine residency programs located outside the seven-county~~  
234.27 ~~metropolitan area, as defined in section 473.121, subdivision 4, focused on education and~~  
234.28 ~~training of family medicine physicians to serve communities outside the metropolitan area.~~  
234.29 ~~To be eligible for a grant under this paragraph, a family medicine residency program must~~  
234.30 ~~demonstrate that over the most recent three calendar years, at least 25 percent of its residents~~  
234.31 ~~practice in Minnesota communities outside the metropolitan area. Grant funds must be~~  
234.32 ~~allocated proportionally based on the number of residents per eligible residency program.~~

234.33 (d) Funds distributed shall not be used to displace current funding appropriations  
234.34 from federal or state sources.

234.35 (e) ~~(d)~~ Funds shall be distributed to the sponsoring institutions indicating the amount  
234.36 to be distributed to each of the sponsor's clinical medical education programs based on the

235.1 criteria in this subdivision and in accordance with the commissioner's approval letter. Each  
235.2 clinical medical education program must distribute funds allocated under paragraphs (a)  
235.3 and (b) to the training sites as specified in the commissioner's approval letter. Sponsoring  
235.4 institutions, which are accredited through an organization recognized by the Department  
235.5 of Education or the Centers for Medicare and Medicaid Services, may contract directly  
235.6 with training sites to provide clinical training. To ensure the quality of clinical training,  
235.7 those accredited sponsoring institutions must:

235.8 (1) develop contracts specifying the terms, expectations, and outcomes of the clinical  
235.9 training conducted at sites; and

235.10 (2) take necessary action if the contract requirements are not met. Action may include  
235.11 the withholding of payments under this section or the removal of students from the site.

235.12 ~~(f)~~ (e) Use of funds is limited to expenses related to clinical training program costs  
235.13 for eligible programs.

235.14 ~~(g)~~ (f) Any funds not distributed in accordance with the commissioner's approval  
235.15 letter must be returned to the medical education and research fund within 30 days of  
235.16 receiving notice from the commissioner. The commissioner shall distribute returned funds  
235.17 to the appropriate training sites in accordance with the commissioner's approval letter.

235.18 ~~(h)~~ (g) A maximum of \$150,000 of the funds dedicated to the commissioner  
235.19 under section 297F.10, subdivision 1, clause (2), may be used by the commissioner for  
235.20 administrative expenses associated with implementing this section.

235.21 Sec. 9. Minnesota Statutes 2014, section 62U.04, subdivision 11, is amended to read:

235.22 Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding  
235.23 subdivision 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the  
235.24 commissioner's designee shall only use the data submitted under subdivisions 4 and 5 for  
235.25 the following purposes:

235.26 (1) to evaluate the performance of the health care home program as authorized under  
235.27 sections 256B.0751, subdivision 6, and 256B.0752, subdivision 2;

235.28 (2) to study, in collaboration with the reducing avoidable readmissions effectively  
235.29 (RARE) campaign, hospital readmission trends and rates;

235.30 (3) to analyze variations in health care costs, quality, utilization, and illness burden  
235.31 based on geographical areas or populations; ~~and~~

235.32 (4) to evaluate the state innovation model (SIM) testing grant received by the  
235.33 Departments of Health and Human Services, including the analysis of health care cost,  
235.34 quality, and utilization baseline and trend information for targeted populations and  
235.35 communities; and

- 236.1 (5) to compile one or more public use files of summary data or tables that must:  
236.2 (i) be available to the public for no or minimal cost by March 1, 2016, and available  
236.3 by Web-based electronic data download by June 30, 2019;  
236.4 (ii) not identify individual patients, payers, or providers;  
236.5 (iii) be updated by the commissioner, at least annually, with the most current data  
236.6 available;  
236.7 (iv) contain clear and conspicuous explanations of the characteristics of the data,  
236.8 such as the dates of the data contained in the files, the absence of costs of care for uninsured  
236.9 patients or nonresidents, and other disclaimers that provide appropriate context; and  
236.10 (v) not lead to the collection of additional data elements beyond what is authorized  
236.11 under this section as of June 30, 2015.
- 236.12 (b) The commissioner may publish the results of the authorized uses identified  
236.13 in paragraph (a) so long as the data released publicly do not contain information or  
236.14 descriptions in which the identity of individual hospitals, clinics, or other providers may  
236.15 be discerned.
- 236.16 (c) Nothing in this subdivision shall be construed to prohibit the commissioner from  
236.17 using the data collected under subdivision 4 to complete the state-based risk adjustment  
236.18 system assessment due to the legislature on October 1, 2015.
- 236.19 (d) The commissioner or the commissioner's designee may use the data submitted  
236.20 under subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until  
236.21 July 1, 2016.
- 236.22 (e) The commissioner shall consult with the all-payer claims database work group  
236.23 established under subdivision 12 regarding the technical considerations necessary to create  
236.24 the public use files of summary data described in paragraph (a), clause (5).

236.25 Sec. 10. Minnesota Statutes 2014, section 144.1501, subdivision 1, is amended to read:

236.26 Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions  
236.27 apply.

236.28 (b) "Advanced dental therapist" means an individual who is licensed as a dental  
236.29 therapist under section 150A.06, and who is certified as an advanced dental therapist  
236.30 under section 150A.106.

236.31 (c) "Dental therapist" means an individual who is licensed as a dental therapist  
236.32 under section 150A.06.

236.33 ~~(b)~~ (d) "Dentist" means an individual who is licensed to practice dentistry.

236.34 ~~(e)~~ (e) "Designated rural area" means a statutory and home rule charter city or  
236.35 township that is:

237.1 ~~(t)~~ outside the seven-county metropolitan area as defined in section 473.121,  
 237.2 subdivision 2; ~~and, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and~~  
 237.3 St. Cloud.

237.4 ~~(2) has a population under 15,000.~~

237.5 ~~(d)~~ (f) "Emergency circumstances" means those conditions that make it impossible  
 237.6 for the participant to fulfill the service commitment, including death, total and permanent  
 237.7 disability, or temporary disability lasting more than two years.

237.8 (g) "Mental health professional" means an individual providing clinical services in  
 237.9 the treatment of mental illness who is qualified in at least one of the ways specified in  
 237.10 section 245.462, subdivision 18.

237.11 ~~(e)~~ (h) "Medical resident" means an individual participating in a medical residency  
 237.12 in family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

237.13 ~~(f)~~ (i) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse  
 237.14 anesthetist, advanced clinical nurse specialist, or physician assistant.

237.15 ~~(g)~~ (j) "Nurse" means an individual who has completed training and received  
 237.16 all licensing or certification necessary to perform duties as a licensed practical nurse  
 237.17 or registered nurse.

237.18 ~~(h)~~ (k) "Nurse-midwife" means a registered nurse who has graduated from a program  
 237.19 of study designed to prepare registered nurses for advanced practice as nurse-midwives.

237.20 ~~(i)~~ (l) "Nurse practitioner" means a registered nurse who has graduated from a  
 237.21 program of study designed to prepare registered nurses for advanced practice as nurse  
 237.22 practitioners.

237.23 ~~(j)~~ (m) "Pharmacist" means an individual with a valid license issued under chapter  
 237.24 151.

237.25 ~~(k)~~ (n) "Physician" means an individual who is licensed to practice medicine in  
 237.26 the areas of family practice, internal medicine, obstetrics and gynecology, pediatrics,  
 237.27 or psychiatry.

237.28 ~~(l)~~ (o) "Physician assistant" means a person licensed under chapter 147A.

237.29 (p) "Public health nurse" means a registered nurse licensed in Minnesota who has  
 237.30 obtained a registration certificate as a public health nurse from the Board of Nursing in  
 237.31 accordance with Minnesota Rules, chapter 6316.

237.32 ~~(m)~~ (q) "Qualified educational loan" means a government, commercial, or foundation  
 237.33 loan for actual costs paid for tuition, reasonable education expenses, and reasonable living  
 237.34 expenses related to the graduate or undergraduate education of a health care professional.

237.35 ~~(n)~~ (r) "Underserved urban community" means a Minnesota urban area or population  
 237.36 included in the list of designated primary medical care health professional shortage areas

238.1 (HPSAs), medically underserved areas (MUAs), or medically underserved populations  
238.2 (MUPs) maintained and updated by the United States Department of Health and Human  
238.3 Services.

238.4 Sec. 11. Minnesota Statutes 2014, section 144.1501, subdivision 2, is amended to read:

238.5 Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness  
238.6 program account is established. The commissioner of health shall use money from the  
238.7 account to establish a loan forgiveness program:

238.8 (1) for medical residents and mental health professionals agreeing to practice  
238.9 in designated rural areas or underserved urban communities or specializing in the area  
238.10 of pediatric psychiatry;

238.11 (2) for midlevel practitioners agreeing to practice in designated rural areas or to  
238.12 teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary  
238.13 program at the undergraduate level or the equivalent at the graduate level;

238.14 (3) for nurses who agree to practice in a Minnesota nursing home ~~or~~; an intermediate  
238.15 care facility for persons with developmental disability; or a hospital if the hospital owns  
238.16 and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked  
238.17 by the nurse is in the nursing home; or agree to teach at least 12 credit hours, or 720 hours  
238.18 per year in the nursing field in a postsecondary program at the undergraduate level or the  
238.19 equivalent at the graduate level;

238.20 (4) for other health care technicians agreeing to teach at least 12 credit hours, or 720  
238.21 hours per year in their designated field in a postsecondary program at the undergraduate  
238.22 level or the equivalent at the graduate level. The commissioner, in consultation with  
238.23 the Healthcare Education-Industry Partnership, shall determine the health care fields  
238.24 where the need is the greatest, including, but not limited to, respiratory therapy, clinical  
238.25 laboratory technology, radiologic technology, and surgical technology;

238.26 (5) for pharmacists, advanced dental therapists, dental therapists, and public health  
238.27 nurses who agree to practice in designated rural areas; and

238.28 (6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient  
238.29 encounters to state public program enrollees or patients receiving sliding fee schedule  
238.30 discounts through a formal sliding fee schedule meeting the standards established by  
238.31 the United States Department of Health and Human Services under Code of Federal  
238.32 Regulations, title 42, section 51, chapter 303.

238.33 (b) Appropriations made to the account do not cancel and are available until  
238.34 expended, except that at the end of each biennium, any remaining balance in the account

239.1 that is not committed by contract and not needed to fulfill existing commitments shall  
 239.2 cancel to the fund.

239.3 Sec. 12. Minnesota Statutes 2014, section 144.1501, subdivision 3, is amended to read:

239.4 Subd. 3. **Eligibility.** (a) To be eligible to participate in the loan forgiveness program,  
 239.5 an individual must:

239.6 (1) be a medical or dental resident; a licensed pharmacist; or be enrolled in a training  
 239.7 or education program to become a dentist, dental therapist, advanced dental therapist,  
 239.8 mental health professional, pharmacist, public health nurse, midlevel practitioner,  
 239.9 registered nurse, or a licensed practical nurse training program. The commissioner may  
 239.10 also consider applications submitted by graduates in eligible professions who are licensed  
 239.11 and in practice; and

239.12 (2) submit an application to the commissioner of health. ~~If fewer applications are~~  
 239.13 ~~submitted by dental students or residents than there are dentist participant slots available,~~  
 239.14 ~~the commissioner may consider applications submitted by dental program graduates~~  
 239.15 ~~who are licensed dentists.~~

239.16 (b) An applicant selected to participate must sign a contract to agree to serve a  
 239.17 minimum three-year full-time service obligation according to subdivision 2, which  
 239.18 shall begin no later than March 31 following completion of required training, with the  
 239.19 exception of a nurse, who must agree to serve a minimum two-year full-time service  
 239.20 obligation according to subdivision 2, which shall begin no later than March 31 following  
 239.21 completion of required training.

239.22 Sec. 13. Minnesota Statutes 2014, section 144.1501, subdivision 4, is amended to read:

239.23 Subd. 4. **Loan forgiveness.** The commissioner of health may select applicants  
 239.24 each year for participation in the loan forgiveness program, within the limits of available  
 239.25 funding. In considering applications, the commissioner shall give preference to applicants  
 239.26 who document diverse cultural competencies. The commissioner shall distribute available  
 239.27 funds for loan forgiveness proportionally among the eligible professions according to the  
 239.28 vacancy rate for each profession in the required geographic area, facility type, teaching  
 239.29 area, patient group, or specialty type specified in subdivision 2. The commissioner shall  
 239.30 allocate funds for physician loan forgiveness so that 75 percent of the funds available are  
 239.31 used for rural physician loan forgiveness and 25 percent of the funds available are used  
 239.32 for underserved urban communities and pediatric psychiatry loan forgiveness. If the  
 239.33 commissioner does not receive enough qualified applicants each year to use the entire  
 239.34 allocation of funds for any eligible profession, the remaining funds may be allocated

240.1 proportionally among the other eligible professions according to the vacancy rate for  
240.2 each profession in the required geographic area, patient group, or facility type specified  
240.3 in subdivision 2. Applicants are responsible for securing their own qualified educational  
240.4 loans. The commissioner shall select participants based on their suitability for practice  
240.5 serving the required geographic area or facility type specified in subdivision 2, as indicated  
240.6 by experience or training. The commissioner shall give preference to applicants closest to  
240.7 completing their training. For each year that a participant meets the service obligation  
240.8 required under subdivision 3, up to a maximum of four years, the commissioner shall make  
240.9 annual disbursements directly to the participant equivalent to 15 percent of the average  
240.10 educational debt for indebted graduates in their profession in the year closest to the  
240.11 applicant's selection for which information is available, not to exceed the balance of the  
240.12 participant's qualifying educational loans. Before receiving loan repayment disbursements  
240.13 and as requested, the participant must complete and return to the commissioner a  
240.14 confirmation of practice form provided by the commissioner verifying that the participant  
240.15 is practicing as required under subdivisions 2 and 3. The participant must provide the  
240.16 commissioner with verification that the full amount of loan repayment disbursement  
240.17 received by the participant has been applied toward the designated loans. After each  
240.18 disbursement, verification must be received by the commissioner and approved before the  
240.19 next loan repayment disbursement is made. Participants who move their practice remain  
240.20 eligible for loan repayment as long as they practice as required under subdivision 2.

240.21 Sec. 14. **[144.1911] INTERNATIONAL MEDICAL GRADUATES ASSISTANCE**  
240.22 **PROGRAM.**

240.23 Subdivision 1. **Establishment.** The international medical graduates assistance  
240.24 program is established to address barriers to practice and facilitate pathways to assist  
240.25 immigrant international medical graduates to integrate into the Minnesota health  
240.26 care delivery system, with the goal of increasing access to primary care in rural and  
240.27 underserved areas of the state.

240.28 Subd. 2. **Definitions.** (a) For the purposes of this section, the following terms  
240.29 have the meanings given.

240.30 (b) "Commissioner" means the commissioner of health.

240.31 (c) "Immigrant international medical graduate" means an international medical  
240.32 graduate who was born outside the United States, now resides permanently in the United  
240.33 States, and who did not enter the United States on a J1 or similar nonimmigrant visa  
240.34 following acceptance into a United States medical residency or fellowship program.



241.1 (d) "International medical graduate" means a physician who received a basic medical  
241.2 degree or qualification from a medical school located outside the United States and Canada.

241.3 (e) "Minnesota immigrant international medical graduate" means an immigrant  
241.4 international medical graduate who has lived in Minnesota for at least two years.

241.5 (f) "Rural community" means a statutory and home rule charter city or township  
241.6 that: (1) is outside the seven-county metropolitan area as defined in section 473.121,  
241.7 subdivision 2; and (2) has a population under 15,000.

241.8 (g) "Underserved community" means a Minnesota area or population included in  
241.9 the list of designated primary medical care health professional shortage areas, medically  
241.10 underserved areas, or medically underserved populations (MUPs) maintained and updated  
241.11 by the United States Department of Health and Human Services.

241.12 Subd. 3. **Program administration.** (a) In administering the international medical  
241.13 graduates assistance program, the commissioner shall:

241.14 (1) provide overall coordination for the planning, development, and implementation  
241.15 of a comprehensive system for integrating qualified immigrant international medical  
241.16 graduates into the Minnesota health care delivery system, particularly those willing to  
241.17 serve in rural or underserved communities of the state;

241.18 (2) develop and maintain, in partnership with community organizations working  
241.19 with international medical graduates, a voluntary roster of immigrant international medical  
241.20 graduates interested in entering the Minnesota health workforce to assist in planning  
241.21 and program administration, including making available summary reports that show the  
241.22 aggregate number and distribution, by geography and specialty, of immigrant international  
241.23 medical graduates in Minnesota;

241.24 (3) work with graduate clinical medical training programs to address barriers  
241.25 faced by immigrant international medical graduates in securing residency positions in  
241.26 Minnesota, including the requirement that applicants for residency positions be recent  
241.27 graduates of medical school. The annual report required in subdivision 10 shall include  
241.28 any progress in addressing these barriers;

241.29 (4) develop a system to assess and certify the clinical readiness of eligible immigrant  
241.30 international medical graduates to serve in a residency program. The system shall  
241.31 include assessment methods, an operating plan, and a budget. Initially, the commissioner  
241.32 may develop assessments for clinical readiness for practice of one or more primary  
241.33 care specialties, and shall add additional assessments as resources are available. The  
241.34 commissioner may contract with an independent entity or another state agency to conduct  
241.35 the assessments. In order to be assessed for clinical readiness for residency, an eligible  
241.36 international medical graduate must have obtained a certification from the Educational

242.1 Commission of Foreign Medical Graduates. The commissioner shall issue a Minnesota  
242.2 certificate of clinical readiness for residency to those who pass the assessment;

242.3 (5) explore and facilitate more streamlined pathways for immigrant international  
242.4 medical graduates to serve in nonphysician professions in the Minnesota workforce; and

242.5 (6) study, in consultation with the Board of Medical Practice and other stakeholders,  
242.6 changes necessary in health professional licensure and regulation to ensure full utilization  
242.7 of immigrant international medical graduates in the Minnesota health care delivery  
242.8 system. The commissioner shall include recommendations in the annual report required  
242.9 under subdivision 10, due January 15, 2017.

242.10 Subd. 4. **Career guidance and support services.** (a) The commissioner shall  
242.11 award grants to eligible nonprofit organizations to provide career guidance and support  
242.12 services to immigrant international medical graduates seeking to enter the Minnesota  
242.13 health workforce. Eligible grant activities include the following:

242.14 (1) educational and career navigation, including information on training and  
242.15 licensing requirements for physician and nonphysician health care professions, and  
242.16 guidance in determining which pathway is best suited for an individual international  
242.17 medical graduate based on the graduate's skills, experience, resources, and interests;

242.18 (2) support in becoming proficient in medical English;

242.19 (3) support in becoming proficient in the use of information technology, including  
242.20 computer skills and use of electronic health record technology;

242.21 (4) support for increasing knowledge of and familiarity with the United States  
242.22 health care system;

242.23 (5) support for other foundational skills identified by the commissioner;

242.24 (6) support for immigrant international medical graduates in becoming certified  
242.25 by the Educational Commission on Foreign Medical Graduates, including help with  
242.26 preparation for required licensing examinations and financial assistance for fees; and

242.27 (7) assistance to international medical graduates in registering with the program's  
242.28 Minnesota international medical graduate roster.

242.29 (b) The commissioner shall award the initial grants under this subdivision by  
242.30 December 31, 2015.

242.31 Subd. 5. **Clinical preparation.** (a) The commissioner shall award grants to support  
242.32 clinical preparation for Minnesota international medical graduates needing additional  
242.33 clinical preparation or experience to qualify for residency. The grant program shall include:

242.34 (1) proposed training curricula;

242.35 (2) associated policies and procedures for clinical training sites, which must be part  
242.36 of existing clinical medical education programs in Minnesota; and

243.1 (3) monthly stipends for international medical graduate participants. Priority shall  
243.2 be given to primary care sites in rural or underserved areas of the state, and international  
243.3 medical graduate participants must commit to serving at least five years in a rural or  
243.4 underserved community of the state.

243.5 (b) The policies and procedures for the clinical preparation grants must be developed  
243.6 by December 31, 2015, including an implementation schedule that begins awarding grants  
243.7 to clinical preparation programs beginning in June of 2016.

243.8 Subd. 6. **International medical graduate primary care residency grant program**

243.9 **and revolving account.** (a) The commissioner shall award grants to support primary  
243.10 care residency positions designated for Minnesota immigrant physicians who are willing  
243.11 to serve in rural or underserved areas of the state. No grant shall exceed \$150,000 per  
243.12 residency position per year. Eligible primary care residency grant recipients include  
243.13 accredited family medicine, internal medicine, obstetrics and gynecology, psychiatry, and  
243.14 pediatric residency programs. Eligible primary care residency programs shall apply to the  
243.15 commissioner. Applications must include the number of anticipated residents to be funded  
243.16 using grant funds and a budget. Notwithstanding any law to the contrary, funds awarded  
243.17 to grantees in a grant agreement do not lapse until the grant agreement expires. Before any  
243.18 funds are distributed, a grant recipient shall provide the commissioner with the following:

243.19 (1) a copy of the signed contract between the primary care residency program and  
243.20 the participating international medical graduate;

243.21 (2) certification that the participating international medical graduate has lived in  
243.22 Minnesota for at least two years and is certified by the Educational Commission on  
243.23 Foreign Medical Graduates. Residency programs may also require that participating  
243.24 international medical graduates hold a Minnesota certificate of clinical readiness for  
243.25 residency, once the certificates become available; and

243.26 (3) verification that the participating international medical graduate has executed a  
243.27 participant agreement pursuant to paragraph (b).

243.28 (b) Upon acceptance by a participating residency program, international medical  
243.29 graduates shall enter into an agreement with the commissioner to provide primary  
243.30 care for at least five years in a rural or underserved area of Minnesota after graduating  
243.31 from the residency program and make payments to the revolving international medical  
243.32 graduate residency account for five years beginning in their second year of postresidency  
243.33 employment. Participants shall pay \$15,000 or ten percent of their annual compensation  
243.34 each year, whichever is less.

243.35 (c) A revolving international medical graduate residency account is established  
243.36 as an account in the special revenue fund in the state treasury. The commissioner of

244.1 management and budget shall credit to the account appropriations, payments, and  
244.2 transfers to the account. Earnings, such as interest, dividends, and any other earnings  
244.3 arising from fund assets, must be credited to the account. Funds in the account are  
244.4 appropriated annually to the commissioner to award grants and administer the grant  
244.5 program established in paragraph (a). Notwithstanding any law to the contrary, any funds  
244.6 deposited in the account do not expire. The commissioner may accept contributions to the  
244.7 account from private sector entities subject to the following provisions:

244.8 (1) the contributing entity may not specify the recipient or recipients of any grant  
244.9 issued under this subdivision;

244.10 (2) the commissioner shall make public the identity of any private contributor to the  
244.11 account, as well as the amount of the contribution provided; and

244.12 (3) a contributing entity may not specify that the recipient or recipients of any funds  
244.13 use specific products or services, nor may the contributing entity imply that a contribution  
244.14 is an endorsement of any specific product or service.

244.15 Subd. 7. **Voluntary hospital programs.** A hospital may establish residency  
244.16 programs for foreign-trained physicians to become candidates for licensure to practice  
244.17 medicine in the state of Minnesota. A hospital may partner with organizations, such as  
244.18 the New Americans Alliance for Development, to screen for and identify foreign-trained  
244.19 physicians eligible for a hospital's particular residency program.

244.20 Subd. 8. **Board of Medical Practice.** Nothing in this section alters the authority of  
244.21 the Board of Medical Practice to regulate the practice of medicine.

244.22 Subd. 9. **Consultation with stakeholders.** The commissioner shall administer the  
244.23 international medical graduates assistance program, including the grant programs described  
244.24 under subdivisions 4, 5, and 6, in consultation with representatives of the following sectors:

244.25 (1) state agencies:

244.26 (i) Board of Medical Practice;

244.27 (ii) Office of Higher Education; and

244.28 (iii) Department of Employment and Economic Development;

244.29 (2) health care industry:

244.30 (i) a health care employer in a rural or underserved area of Minnesota;

244.31 (ii) a health plan company;

244.32 (iii) the Minnesota Medical Association;

244.33 (iv) licensed physicians experienced in working with international medical  
244.34 graduates; and

244.35 (v) the Minnesota Academy of Physician Assistants;

244.36 (3) community-based organizations:

- 245.1 (i) organizations serving immigrant and refugee communities of Minnesota;  
245.2 (ii) organizations serving the international medical graduate community, such as the  
245.3 New Americans Alliance for Development and Women's Initiative for Self Empowerment;  
245.4 and  
245.5 (iii) the Minnesota Association of Community Health Centers;  
245.6 (4) higher education:  
245.7 (i) University of Minnesota;  
245.8 (ii) Mayo Clinic School of Health Professions;  
245.9 (iii) graduate medical education programs not located at the University of Minnesota  
245.10 or Mayo Clinic School of Health Professions; and  
245.11 (iv) Minnesota physician assistant education program; and  
245.12 (5) two international medical graduates.

245.13 Subd. 10. **Report.** The commissioner shall submit an annual report to the chairs and  
245.14 ranking minority members of the legislative committees with jurisdiction over health care  
245.15 and higher education on the progress of the integration of international medical graduates  
245.16 into the Minnesota health care delivery system. The report shall include recommendations  
245.17 on actions needed for continued progress integrating international medical graduates. The  
245.18 report shall be submitted by January 15 each year, beginning January 15, 2016.

245.19 Sec. 15. Minnesota Statutes 2014, section 144.215, is amended by adding a subdivision  
245.20 to read:

245.21 Subd. 4a. **Parent contact information.** The mailing or residence address, other  
245.22 than the city or county, e-mail address, and telephone number of a parent provided in  
245.23 connection with the electronic registration of a birth or application for a birth certificate  
245.24 are private data on individuals, provided that the data may be disclosed to a school or a  
245.25 local, state, tribal, or federal government entity to the extent that the data are necessary for  
245.26 the entity to perform its duties.

245.27 Sec. 16. Minnesota Statutes 2014, section 144.225, subdivision 4, is amended to read:

245.28 Subd. 4. **Access to records for research purposes.** The state registrar may permit  
245.29 persons performing medical research access to the information restricted in subdivision 2  
245.30 or 2a, or section 144.215, subdivision 4a, if those persons agree in writing not to disclose  
245.31 private or confidential data on individuals.

245.32 Sec. 17. Minnesota Statutes 2014, section 144.291, subdivision 2, is amended to read:

246.1 Subd. 2. **Definitions.** For the purposes of sections 144.291 to 144.298, the following  
246.2 terms have the meanings given.

246.3 (a) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

246.4 (b) "Health information exchange" means a legal arrangement between health care  
246.5 providers and group purchasers to enable and oversee the business and legal issues  
246.6 involved in the electronic exchange of health records between the entities for the delivery  
246.7 of patient care.

246.8 (c) "Health record" means any information, whether oral or recorded in any form or  
246.9 medium, that relates to the past, present, or future physical or mental health or condition of  
246.10 a patient; the provision of health care to a patient; or the past, present, or future payment  
246.11 for the provision of health care to a patient.

246.12 (d) "Identifying information" means the patient's name, address, date of birth,  
246.13 gender, parent's or guardian's name regardless of the age of the patient, and other  
246.14 nonclinical data which can be used to uniquely identify a patient.

246.15 (e) "Individually identifiable form" means a form in which the patient is or can be  
246.16 identified as the subject of the health records.

246.17 (f) "Medical emergency" means medically necessary care which is immediately  
246.18 needed to preserve life, prevent serious impairment to bodily functions, organs, or parts,  
246.19 or prevent placing the physical or mental health of the patient in serious jeopardy.

246.20 (g) "Patient" means a natural person who has received health care services from a  
246.21 provider for treatment or examination of a medical, psychiatric, or mental condition, the  
246.22 surviving spouse and parents of a deceased patient, or a person the patient appoints in  
246.23 writing as a representative, including a health care agent acting according to chapter 145C,  
246.24 unless the authority of the agent has been limited by the principal in the principal's health  
246.25 care directive. Except for minors who have received health care services under sections  
246.26 144.341 to 144.347, in the case of a minor, patient includes a parent or guardian, or a  
246.27 person acting as a parent or guardian in the absence of a parent or guardian.

246.28 (h) "Patient information service" means a service providing the following query  
246.29 options: a record locator service as defined in section 144.291, subdivision 2, paragraph  
246.30 (i), or a master patient index or clinical data repository as defined in section 62J.498,  
246.31 subdivision 1.

246.32 ~~(h)~~ (i) "Provider" means:

246.33 (1) any person who furnishes health care services and is regulated to furnish the  
246.34 services under chapter 147, 147A, 147B, 147C, 147D, 148, 148B, 148D, 148F, 150A,  
246.35 151, 153, or 153A;

246.36 (2) a home care provider licensed under section ~~144A.46~~ 144A.471;

247.1 (3) a health care facility licensed under this chapter or chapter 144A; and

247.2 (4) a physician assistant registered under chapter 147A.

247.3 ~~(j)~~ (j) "Record locator service" means an electronic index of patient identifying  
247.4 information that directs providers in a health information exchange to the location of  
247.5 patient health records held by providers and group purchasers.

247.6 ~~(k)~~ (k) "Related health care entity" means an affiliate, as defined in section 144.6521,  
247.7 subdivision 3, paragraph (b), of the provider releasing the health records.

247.8 Sec. 18. Minnesota Statutes 2014, section 144.293, subdivision 8, is amended to read:

247.9 Subd. 8. **Record locator or patient information service.** (a) A provider or group  
247.10 purchaser may release patient identifying information and information about the location  
247.11 of the patient's health records to a record locator or patient information service without  
247.12 consent from the patient, unless the patient has elected to be excluded from the service  
247.13 under paragraph (d). The Department of Health may not access the record locator or  
247.14 patient information service or receive data from the ~~record locator~~ service. Only a  
247.15 provider may have access to patient identifying information in a record locator or patient  
247.16 information service. Except in the case of a medical emergency, a provider participating in  
247.17 a health information exchange using a record locator or patient information service does  
247.18 not have access to patient identifying information and information about the location of  
247.19 the patient's health records unless the patient specifically consents to the access. A consent  
247.20 does not expire but may be revoked by the patient at any time by providing written notice  
247.21 of the revocation to the provider.

247.22 (b) A health information exchange maintaining a record locator or patient  
247.23 information service must maintain an audit log of providers accessing information in a  
247.24 ~~record locator~~ the service that at least contains information on:

247.25 (1) the identity of the provider accessing the information;

247.26 (2) the identity of the patient whose information was accessed by the provider; and

247.27 (3) the date the information was accessed.

247.28 (c) No group purchaser may in any way require a provider to participate in a record  
247.29 locator or patient information service as a condition of payment or participation.

247.30 (d) A provider or an entity operating a record locator or patient information service  
247.31 must provide a mechanism under which patients may exclude their identifying information  
247.32 and information about the location of their health records from a record locator or patient  
247.33 information service. At a minimum, a consent form that permits a provider to access  
247.34 a record locator or patient information service must include a conspicuous check-box  
247.35 option that allows a patient to exclude all of the patient's information from the ~~record~~

248.1 ~~locator~~ service. A provider participating in a health information exchange with a record  
 248.2 locator or patient information service who receives a patient's request to exclude all of the  
 248.3 patient's information from the ~~record-locator~~ service or to have a specific provider contact  
 248.4 excluded from the ~~record-locator~~ service is responsible for removing that information  
 248.5 from the ~~record-locator~~ service.

248.6 Sec. 19. Minnesota Statutes 2014, section 144.298, subdivision 2, is amended to read:

248.7 Subd. 2. **Liability of provider or other person.** A person who does any of the  
 248.8 following is liable to the patient for compensatory damages caused by an unauthorized  
 248.9 release or an intentional, unauthorized access, plus costs and reasonable attorney fees:

248.10 (1) negligently or intentionally requests or releases a health record in violation  
 248.11 of sections 144.291 to 144.297;

248.12 (2) forges a signature on a consent form or materially alters the consent form of  
 248.13 another person without the person's consent;

248.14 (3) obtains a consent form or the health records of another person under false  
 248.15 pretenses; or

248.16 (4) intentionally violates sections 144.291 to 144.297 by intentionally accessing a  
 248.17 record locator or patient information service without authorization.

248.18 Sec. 20. Minnesota Statutes 2014, section 144.298, subdivision 3, is amended to read:

248.19 Subd. 3. **Liability for record locator or patient information service.** A patient  
 248.20 is entitled to receive compensatory damages plus costs and reasonable attorney fees  
 248.21 if a health information exchange maintaining a record locator or patient information  
 248.22 service, or an entity maintaining a record locator or patient information service for a  
 248.23 health information exchange, negligently or intentionally violates the provisions of section  
 248.24 144.293, subdivision 8.

248.25 Sec. 21. Minnesota Statutes 2014, section 144.3831, subdivision 1, is amended to read:

248.26 Subdivision 1. **Fee setting.** The commissioner of health may assess an annual fee  
 248.27 of ~~\$6.36~~ \$8.28 for every service connection to a public water supply that is owned or  
 248.28 operated by a home rule charter city, a statutory city, a city of the first class, or a town. The  
 248.29 commissioner of health may also assess an annual fee for every service connection served  
 248.30 by a water user district defined in section 110A.02. Fees collected under this section shall  
 248.31 be deposited in the state treasury and credited to the state government special revenue fund.

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



249.1 Sec. 22. [144.3875] EARLY DENTAL PREVENTION INITIATIVE.

249.2 (a) The commissioner of health, in collaboration with the commissioner of human  
249.3 services, shall implement a statewide initiative to increase awareness among communities  
249.4 of color and recent immigrants on the importance of early preventive dental intervention  
249.5 for infants and toddlers before and after primary teeth appear.

249.6 (b) The commissioner shall develop educational materials and information for  
249.7 expectant and new parents within the targeted communities that include the importance  
249.8 of early dental care to prevent early cavities, including proper cleaning techniques and  
249.9 feeding habits, before and after primary teeth appear.

249.10 (c) The commissioner shall develop a distribution plan to ensure that the materials  
249.11 are distributed to expectant and new parents within the targeted communities, including,  
249.12 but not limited to, making the materials available to health care providers, community  
249.13 clinics, WIC sites, and other relevant sites within the targeted communities.

249.14 (d) In developing these materials and distribution plan, the commissioner shall work  
249.15 collaboratively with members of the targeted communities, dental providers, pediatricians,  
249.16 child care providers, and home visiting nurses.

249.17 (e) The commissioner shall, with input from stakeholders listed in paragraph (d),  
249.18 develop and pilot incentives to encourage early dental care within one year of an infant's  
249.19 teeth erupting.

249.20 Sec. 23. [144.4961] MINNESOTA RADON LICENSING ACT.

249.21 Subdivision 1. Citation. This section may be cited as the "Minnesota Radon  
249.22 Licensing Act."

249.23 Subd. 2. Definitions. (a) As used in this section, the following terms have the  
249.24 meanings given them.

249.25 (b) "Mitigation" means the act of repairing or altering a building or building design  
249.26 for the purpose in whole or in part of reducing the concentration of radon in the indoor  
249.27 atmosphere.

249.28 (c) "Radon" means both the radioactive, gaseous element produced by the  
249.29 disintegration of radium, and the short-lived radionuclides that are decay products of radon.

249.30 Subd. 3. Rulemaking. The commissioner of health shall adopt rules for licensure  
249.31 and enforcement of applicable laws and rules relating to indoor radon in dwellings and  
249.32 other buildings, with the exception of newly constructed Minnesota homes according  
249.33 to section 326B.106, subdivision 6. The commissioner shall coordinate, oversee, and  
249.34 implement all state functions in matters concerning the presence, effects, measurement,  
249.35 and mitigation of risks of radon in dwellings and other buildings.

250.1 Subd. 4. **System tag.** All radon mitigation systems installed in Minnesota on or after  
250.2 October 1, 2017, must have a radon mitigation system tag provided by the commissioner.  
250.3 A radon mitigation professional must attach the tag to the radon mitigation system in  
250.4 a visible location.

250.5 Subd. 5. **License required annually.** A license is required annually for every  
250.6 person, firm, or corporation that sells a device or performs a service for compensation  
250.7 to detect the presence of radon in the indoor atmosphere, performs laboratory analysis,  
250.8 or performs a service to mitigate radon in the indoor atmosphere. This section does not  
250.9 apply to retail stores that only sell or distribute radon sampling but are not engaged in the  
250.10 manufacture of radon sampling devices.

250.11 Subd. 6. **Exemptions.** Radon systems installed in newly constructed Minnesota  
250.12 homes according to section 326B.106, subdivision 6, prior to the issuance of a certificate  
250.13 of occupancy are not required to follow the requirements of this section.

250.14 Subd. 7. **License applications and other reports.** The professionals, companies,  
250.15 and laboratories listed in subdivision 8 must submit applications for licenses, system  
250.16 tags, and any other reporting required under this section and Minnesota Rules on forms  
250.17 prescribed by the commissioner.

250.18 Subd. 8. **Licensing fees.** (a) All radon license applications submitted to the  
250.19 commissioner of health must be accompanied by the required fees. If the commissioner  
250.20 determines that insufficient fees were paid, the necessary additional fees must be paid  
250.21 before the commissioner approves the application. The commissioner shall charge the  
250.22 following fees for each radon license:

250.23 (1) Each measurement professional license, \$300 per year. "Measurement  
250.24 professional" means any person who performs a test to determine the presence and  
250.25 concentration of radon in a building they do not own or lease; provides professional or  
250.26 expert advice on radon testing, radon exposure, or health risks related to radon exposure;  
250.27 or makes representations of doing any of these activities.

250.28 (2) Each mitigation professional license, \$500 per year. "Mitigation professional"  
250.29 means an individual who performs radon mitigation in a building they do not own or  
250.30 lease; provides professional or expert advice on radon mitigation or radon entry routes;  
250.31 or provides on-site supervision of radon mitigation and mitigation technicians; or makes  
250.32 representations of doing any of these activities. This license also permits the licensee to  
250.33 perform the activities of a measurement professional described in clause (1).

250.34 (3) Each mitigation company license, \$500 per year. "Mitigation company" means  
250.35 any business or government entity that performs or authorizes employees to perform radon  
250.36 mitigation. This fee is waived if the company is a sole proprietorship.

251.1 (4) Each radon analysis laboratory license, \$500 per year. "Radon analysis  
251.2 laboratory" means a business entity or government entity that analyzes passive radon  
251.3 detection devices to determine the presence and concentration of radon in the devices.  
251.4 This fee is waived if the laboratory is a government entity and is only distributing test kits  
251.5 for the general public to use in Minnesota.

251.6 (5) Each Minnesota Department of Health radon mitigation system tag, \$75 per tag.  
251.7 "Minnesota Department of Health radon mitigation system tag" or "system tag" means a  
251.8 unique identifiable radon system label provided by the commissioner of health.

251.9 (b) Fees collected under this section shall be deposited in the state treasury and  
251.10 credited to the state government special revenue fund.

251.11 Subd. 9. **Enforcement.** The commissioner shall enforce this section under the  
251.12 provisions of sections 144.989 to 144.993.

251.13 **EFFECTIVE DATE.** This section is effective July 1, 2015, except subdivisions 4  
251.14 and 5, which are effective October 1, 2017.

251.15 Sec. 24. **[144.566] VIOLENCE AGAINST HEALTH CARE WORKERS.**

251.16 Subdivision 1. **Definitions.** (a) The following definitions apply to this section and  
251.17 have the meanings given.

251.18 (b) "Act of violence" means an act by a patient or visitor against a health care  
251.19 worker that includes kicking, scratching, urinating, sexually harassing, or any act defined  
251.20 in sections 609.221 to 609.2241.

251.21 (c) "Commissioner" means the commissioner of health.

251.22 (d) "Health care worker" means any person, whether licensed or unlicensed,  
251.23 employed by, volunteering in, or under contract with a hospital, who has direct contact  
251.24 with a patient of the hospital for purposes of either medical care or emergency response to  
251.25 situations potentially involving violence.

251.26 (e) "Hospital" means any facility licensed as a hospital under section 144.55.

251.27 (f) "Incident response" means the actions taken by hospital administration and health  
251.28 care workers during and following an act of violence.

251.29 (g) "Interfere" means to prevent, impede, discourage, or delay a health care worker's  
251.30 ability to report acts of violence, including by retaliating or threatening to retaliate against  
251.31 a health care worker.

251.32 (h) "Preparedness" means the actions taken by hospital administration and health  
251.33 care workers to prevent a single act of violence or acts of violence generally.

252.1 (i) "Retaliate" means to discharge, discipline, threaten, otherwise discriminate  
252.2 against, or penalize a health care worker regarding the health care worker's compensation,  
252.3 terms, conditions, location, or privileges of employment.

252.4 Subd. 2. **Hospital duties.** (a) All hospitals must design and implement preparedness  
252.5 and incident response action plans to acts of violence by January 15, 2016, and review the  
252.6 plan at least annually thereafter.

252.7 (b) A hospital shall designate a committee of representatives of health care workers  
252.8 employed by the hospital, including nonmanagerial health care workers, nonclinical  
252.9 staff, administrators, patient safety experts, and other appropriate personnel to develop  
252.10 preparedness and incident response action plans to acts of violence. The hospital shall, in  
252.11 consultation with the designated committee, implement the plans under paragraph (a).  
252.12 Nothing in this paragraph shall require the establishment of a separate committee solely  
252.13 for the purpose required by this subdivision.

252.14 (c) A hospital shall provide training to all health care workers employed or  
252.15 contracted with the hospital on safety during acts of violence. Each health care worker  
252.16 must receive safety training annually and upon hire. Training must, at a minimum, include:

252.17 (1) safety guidelines for response to and de-escalation of an act of violence;

252.18 (2) ways to identify potentially violent or abusive situations; and

252.19 (3) the hospital's incident response reaction plan and violence prevention plan.

252.20 (d) As part of its annual review required under paragraph (a), the hospital must  
252.21 review with the designated committee:

252.22 (1) the effectiveness of its preparedness and incident response action plans;

252.23 (2) the most recent gap analysis as provided by the commissioner; and

252.24 (3) the number of acts of violence that occurred in the hospital during the previous  
252.25 year, including injuries sustained, if any, and the unit in which the incident occurred.

252.26 (e) A hospital shall make its action plans and the information listed in paragraph  
252.27 (d) available to local law enforcement and, if any of its workers are represented by a  
252.28 collective bargaining unit, to the exclusive bargaining representatives of those collective  
252.29 bargaining units.

252.30 (f) A hospital, including any individual, partner, association, or any person or group  
252.31 of persons acting directly or indirectly in the interest of the hospital, shall not interfere  
252.32 with or discourage a health care worker if the health care worker wishes to contact law  
252.33 enforcement or the commissioner regarding an act of violence.

252.34 (g) The commissioner may impose an administrative fine of up to \$250 for failure to  
252.35 comply with the requirements of subdivision 2.

253.1 Sec. 25. Minnesota Statutes 2014, section 144.9501, subdivision 6d, is amended to read:

253.2 Subd. 6d. **Certified lead firm.** "Certified lead firm" means a person that employs  
253.3 individuals to perform regulated lead work, with the exception of renovation, and ~~that~~  
253.4 is certified by the commissioner under section 144.9505.

253.5 Sec. 26. Minnesota Statutes 2014, section 144.9501, is amended by adding a  
253.6 subdivision to read:

253.7 Subd. 6e. **Certified renovation firm.** "Certified renovation firm" means a person  
253.8 that employs individuals to perform renovation and is certified by the commissioner  
253.9 under section 144.9505.

253.10 Sec. 27. Minnesota Statutes 2014, section 144.9501, subdivision 22b, is amended to  
253.11 read:

253.12 Subd. 22b. **Lead sampling technician.** "Lead sampling technician" means an  
253.13 individual who performs clearance inspections for renovation sites and lead dust sampling  
253.14 for nonabatement sites, ~~and who is registered with the commissioner under section~~  
253.15 ~~144.9505.~~

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

253.17 Sec. 28. Minnesota Statutes 2014, section 144.9501, subdivision 26b, is amended to  
253.18 read:

253.19 Subd. 26b. **Renovation.** "Renovation" means the modification of any pre-1978  
253.20 affected property that results in the disturbance of known or presumed lead-containing  
253.21 painted surfaces defined under section 144.9508, unless that activity is performed as an  
253.22 ~~abatement~~ lead hazard reduction. A renovation performed for the purpose of converting a  
253.23 building or part of a building into an affected property is a renovation under this subdivision.

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

253.25 Sec. 29. Minnesota Statutes 2014, section 144.9501, is amended by adding a  
253.26 subdivision to read:

253.27 Subd. 26c. **Lead renovator.** "Lead renovator" means an individual who directs  
253.28 individuals who perform renovations. A lead renovator also performs renovation, surface  
253.29 coating testing, and cleaning verification.

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

254.1 Sec. 30. Minnesota Statutes 2014, section 144.9505, is amended to read:

254.2 **144.9505 LICENSING CREDENTIALING OF LEAD FIRMS AND**  
 254.3 **PROFESSIONALS.**

254.4 Subdivision 1. **Licensing and, certification; generally, and permitting.** (a) ~~All~~  
 254.5 ~~Fees received shall be paid~~ collected under this section shall be deposited into the state  
 254.6 treasury and credited to the ~~lead abatement licensing and certification account and are~~  
 254.7 ~~appropriated to the commissioner to cover costs incurred under this section and section~~  
 254.8 ~~144.9508~~ state government special revenue fund.

254.9 (b) Persons shall not advertise or otherwise present themselves as lead supervisors,  
 254.10 lead workers, lead inspectors, lead risk assessors, lead sampling technicians, lead project  
 254.11 designers, ~~or renovation firms, or lead firms unless they have licenses or certificates issued~~  
 254.12 ~~by or are registered with~~ the commissioner under this section.

254.13 (c) The fees required in this section for inspectors, risk assessors, and certified lead  
 254.14 firms are waived for state or local government employees performing services for or  
 254.15 as an assessing agency.

254.16 (d) An individual who is the owner of property on which regulated lead work is to be  
 254.17 performed or an adult individual who is related to the property owner, as defined under  
 254.18 section 245A.02, subdivision 13, is exempt from the requirements to obtain a license and  
 254.19 pay a fee according to this section.

254.20 (e) A person that employs individuals to perform regulated lead work outside of the  
 254.21 person's property must obtain certification as a certified lead firm. An individual who  
 254.22 performs ~~regulated lead work~~ lead hazard reduction, lead hazard screens, lead inspections,  
 254.23 lead risk assessments, clearance inspections, lead project designer services, lead sampling  
 254.24 technician services, swab team services, and activities performed to comply with lead  
 254.25 orders must be employed by a certified lead firm, unless the individual is a sole proprietor  
 254.26 and does not employ any other ~~individual who performs regulated lead work~~ individuals,  
 254.27 the individual is employed by a person that does not perform regulated lead work outside  
 254.28 of the person's property, or the individual is employed by an assessing agency.

254.29 Subd. 1a. **Lead worker license.** Before an individual performs regulated lead work  
 254.30 as a worker, the individual shall first obtain a license from the commissioner. No license  
 254.31 shall be issued unless the individual shows evidence of successfully completing a training  
 254.32 course in lead hazard control. The commissioner shall specify the course of training and  
 254.33 testing requirements and shall charge a \$50 fee annually for the license. License fees are  
 254.34 nonrefundable and must be submitted with each application. The license must be carried  
 254.35 by the individual and be readily available for review by the commissioner and other public  
 254.36 health officials charged with the health, safety, and welfare of the state's citizens.

255.1 Subd. 1b. **Lead supervisor license.** Before an individual performs regulated lead  
255.2 work as a supervisor, the individual shall first obtain a license from the commissioner. No  
255.3 license shall be issued unless the individual shows evidence of experience and successful  
255.4 completion of a training course in lead hazard control. The commissioner shall specify  
255.5 the course of training, experience, and testing requirements and shall charge a \$50 fee  
255.6 annually for the license. License fees are nonrefundable and must be submitted with  
255.7 each application. The license must be carried by the individual and be readily available  
255.8 for review by the commissioner and other public health officials charged with the health,  
255.9 safety, and welfare of the state's citizens.

255.10 Subd. 1c. **Lead inspector license.** Before an individual performs lead inspection  
255.11 services, the individual shall first obtain a license from the commissioner. No license shall  
255.12 be issued unless the individual shows evidence of successfully completing a training  
255.13 course in lead inspection. The commissioner shall specify the course of training and  
255.14 testing requirements and shall charge a \$50 fee annually for the license. License fees are  
255.15 nonrefundable and must be submitted with each application. The license must be carried  
255.16 by the individual and be readily available for review by the commissioner and other public  
255.17 health officials charged with the health, safety, and welfare of the state's citizens.

255.18 Subd. 1d. **Lead risk assessor license.** Before an individual performs lead risk  
255.19 assessor services, the individual shall first obtain a license from the commissioner. No  
255.20 license shall be issued unless the individual shows evidence of experience and successful  
255.21 completion of a training course in lead risk assessment. The commissioner shall specify  
255.22 the course of training, experience, and testing requirements and shall charge a \$100 fee  
255.23 annually for the license. License fees are nonrefundable and must be submitted with  
255.24 each application. The license must be carried by the individual and be readily available  
255.25 for review by the commissioner and other public health officials charged with the health,  
255.26 safety, and welfare of the state's citizens.

255.27 Subd. 1e. **Lead project designer license.** Before an individual performs lead  
255.28 project designer services, the individual shall first obtain a license from the commissioner.  
255.29 No license shall be issued unless the individual shows evidence of experience and  
255.30 successful completion of a training course in lead project design. The commissioner shall  
255.31 specify the course of training, experience, and testing requirements and shall charge a  
255.32 \$100 fee annually for the license. License fees are nonrefundable and must be submitted  
255.33 with each application. The license must be carried by the individual and be readily  
255.34 available for review by the commissioner and other public health officials charged with  
255.35 the health, safety, and welfare of the state's citizens.

256.1 ~~Subd. 1f. **Lead sampling technician.** An individual performing lead sampling~~  
256.2 ~~technician services shall first register with the commissioner. The commissioner shall not~~  
256.3 ~~register an individual unless the individual shows evidence of successfully completing a~~  
256.4 ~~training course in lead sampling. The commissioner shall specify the course of training~~  
256.5 ~~and testing requirements. Proof of registration must be carried by the individual and be~~  
256.6 ~~readily available for review by the commissioner and other public health officials charged~~  
256.7 ~~with the health, safety, and welfare of the state's citizens.~~

256.8 Subd. 1g. **Certified lead firm.** A person who employs individuals to perform  
256.9 regulated lead work, with the exception of renovation, outside of the person's property  
256.10 must obtain certification as a lead firm. The certificate must be in writing, contain an  
256.11 expiration date, be signed by the commissioner, and give the name and address of the  
256.12 person to whom it is issued. A lead firm certificate is valid for one year. The certification  
256.13 fee is \$100, is nonrefundable, and must be submitted with each application. The lead firm  
256.14 certificate or a copy of the certificate must be readily available at the worksite for review  
256.15 by the contracting entity, the commissioner, and other public health officials charged with  
256.16 the health, safety, and welfare of the state's citizens.

256.17 Subd. 1h. **Certified renovation firm.** A person who employs individuals to  
256.18 perform renovation activities outside of the person's property must obtain certification  
256.19 as a renovation firm. The certificate must be in writing, contain an expiration date, be  
256.20 signed by the commissioner, and give the name and address of the person to whom it is  
256.21 issued. A renovation firm certificate is valid for two years. The certification fee is \$100,  
256.22 is nonrefundable, and must be submitted with each application. The renovation firm  
256.23 certificate or a copy of the certificate must be readily available at the worksite for review  
256.24 by the contracting entity, the commissioner, and other public health officials charged with  
256.25 the health, safety, and welfare of the state's citizens.

256.26 Subd. 1i. **Lead training course.** Before a person provides training to lead  
256.27 workers, lead supervisors, lead inspectors, lead risk assessors, lead project designers, lead  
256.28 sampling technicians, and lead renovators, the person shall first obtain a permit from the  
256.29 commissioner. The permit must be in writing, contain an expiration date, be signed by  
256.30 the commissioner, and give the name and address of the person to whom it is issued.  
256.31 A training course permit is valid for two years. Training course permit fees shall be  
256.32 nonrefundable and must be submitted with each application in the amount of \$500 for an  
256.33 initial training course, \$250 for renewal of a permit for an initial training course, \$250 for  
256.34 a refresher training course, and \$125 for renewal of a permit of a refresher training course.

256.35 Subd. 3. **Licensed building contractor; information.** The commissioner shall  
256.36 provide health and safety information on lead abatement and lead hazard reduction to all



257.1 residential building contractors licensed under section 326B.805. The information must  
 257.2 include the lead-safe practices and any other materials describing ways to protect the  
 257.3 health and safety of both employees and residents.

257.4 Subd. 4. **Notice of regulated lead work.** (a) At least five working days before  
 257.5 starting work at each regulated lead worksite, the person performing the regulated lead  
 257.6 work shall give written notice to the commissioner and the appropriate board of health.

257.7 (b) This provision does not apply to lead hazard screen, lead inspection, lead risk  
 257.8 assessment, lead sampling technician, renovation, or lead project design activities.

257.9 Subd. 6. **Duties of contracting entity.** A contracting entity intending to have  
 257.10 regulated lead work performed for its benefit shall include in the specifications and  
 257.11 contracts for the work a requirement that the work be performed by contractors and  
 257.12 subcontractors licensed by the commissioner under sections 144.9501 to 144.9512 and  
 257.13 according to rules adopted by the commissioner related to regulated lead work. No  
 257.14 contracting entity shall allow regulated lead work to be performed for its benefit unless the  
 257.15 contracting entity has seen that the person has a valid license or certificate. A contracting  
 257.16 entity's failure to comply with this subdivision does not relieve a person from any  
 257.17 responsibility under sections 144.9501 to 144.9512.

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

257.19 Sec. 31. Minnesota Statutes 2014, section 144.9508, is amended to read:

257.20 **144.9508 RULES.**

257.21 Subdivision 1. **Sampling and analysis.** The commissioner shall adopt, by rule,  
 257.22 methods for:

257.23 (1) lead inspections, lead hazard screens, lead risk assessments, and clearance  
 257.24 inspections;

257.25 (2) environmental surveys of lead in paint, soil, dust, and drinking water to determine  
 257.26 areas at high risk for toxic lead exposure;

257.27 (3) soil sampling for soil used as replacement soil;

257.28 (4) drinking water sampling, which shall be done in accordance with lab certification  
 257.29 requirements and analytical techniques specified by Code of Federal Regulations, title  
 257.30 40, section 141.89; and

257.31 (5) sampling to determine whether at least 25 percent of the soil samples collected  
 257.32 from a census tract within a standard metropolitan statistical area contain lead in  
 257.33 concentrations that exceed 100 parts per million.

258.1           Subd. 2. **Regulated lead work standards and methods.** (a) The commissioner shall  
258.2 adopt rules establishing regulated lead work standards and methods in accordance with the  
258.3 provisions of this section, for lead in paint, dust, drinking water, and soil in a manner that  
258.4 protects public health and the environment for all residences, including residences also  
258.5 used for a commercial purpose, child care facilities, playgrounds, and schools.

258.6           (b) In the rules required by this section, the commissioner shall require lead hazard  
258.7 reduction of intact paint only if the commissioner finds that the intact paint is on a  
258.8 chewable or lead-dust producing surface that is a known source of actual lead exposure to  
258.9 a specific individual. The commissioner shall prohibit methods that disperse lead dust into  
258.10 the air that could accumulate to a level that would exceed the lead dust standard specified  
258.11 under this section. The commissioner shall work cooperatively with the commissioner  
258.12 of administration to determine which lead hazard reduction methods adopted under this  
258.13 section may be used for lead-safe practices including prohibited practices, preparation,  
258.14 disposal, and cleanup. The commissioner shall work cooperatively with the commissioner  
258.15 of the Pollution Control Agency to develop disposal procedures. In adopting rules under  
258.16 this section, the commissioner shall require the best available technology for regulated  
258.17 lead work methods, paint stabilization, and repainting.

258.18           (c) The commissioner of health shall adopt regulated lead work standards and  
258.19 methods for lead in bare soil in a manner to protect public health and the environment.  
258.20 The commissioner shall adopt a maximum standard of 100 parts of lead per million in  
258.21 bare soil. The commissioner shall set a soil replacement standard not to exceed 25 parts  
258.22 of lead per million. Soil lead hazard reduction methods shall focus on erosion control  
258.23 and covering of bare soil.

258.24           (d) The commissioner shall adopt regulated lead work standards and methods for lead  
258.25 in dust in a manner to protect the public health and environment. Dust standards shall use  
258.26 a weight of lead per area measure and include dust on the floor, on the window sills, and  
258.27 on window wells. Lead hazard reduction methods for dust shall focus on dust removal and  
258.28 other practices which minimize the formation of lead dust from paint, soil, or other sources.

258.29           (e) The commissioner shall adopt lead hazard reduction standards and methods for  
258.30 lead in drinking water both at the tap and public water supply system or private well  
258.31 in a manner to protect the public health and the environment. The commissioner may  
258.32 adopt the rules for controlling lead in drinking water as contained in Code of Federal  
258.33 Regulations, title 40, part 141. Drinking water lead hazard reduction methods may include  
258.34 an educational approach of minimizing lead exposure from lead in drinking water.

259.1 (f) The commissioner of the Pollution Control Agency shall adopt rules to ensure that  
259.2 removal of exterior lead-based coatings from residences and steel structures by abrasive  
259.3 blasting methods is conducted in a manner that protects health and the environment.

259.4 (g) All regulated lead work standards shall provide reasonable margins of safety that  
259.5 are consistent with more than a summary review of scientific evidence and an emphasis on  
259.6 overprotection rather than underprotection when the scientific evidence is ambiguous.

259.7 (h) No unit of local government shall have an ordinance or regulation governing  
259.8 regulated lead work standards or methods for lead in paint, dust, drinking water, or soil  
259.9 that require a different regulated lead work standard or method than the standards or  
259.10 methods established under this section.

259.11 (i) Notwithstanding paragraph (h), the commissioner may approve the use by a unit  
259.12 of local government of an innovative lead hazard reduction method which is consistent  
259.13 in approach with methods established under this section.

259.14 (j) The commissioner shall adopt rules for issuing lead orders required under section  
259.15 144.9504, rules for notification of abatement or interim control activities requirements,  
259.16 and other rules necessary to implement sections 144.9501 to 144.9512.

259.17 (k) The commissioner shall adopt rules consistent with section 402(c)(3) of the  
259.18 Toxic Substances Control Act to ensure that renovation in a pre-1978 affected property  
259.19 where a child or pregnant female resides is conducted in a manner that protects health  
259.20 and the environment. Notwithstanding sections 14.125 and 14.128, the authority to adopt  
259.21 these rules does not expire.

259.22 (l) The commissioner shall adopt rules consistent with sections 406(a) and 406(b)  
259.23 of the Toxic Substances Control Act. Notwithstanding sections 14.125 and 14.128, the  
259.24 authority to adopt these rules does not expire.

259.25 Subd. 2a. **Lead standards for exterior surfaces and street dust.** The  
259.26 commissioner may, by rule, establish lead standards for exterior horizontal surfaces,  
259.27 concrete or other impervious surfaces, and street dust on residential property to protect the  
259.28 public health and the environment.

259.29 Subd. 3. **Licensure and certification.** The commissioner shall adopt rules to license  
259.30 lead supervisors, lead workers, lead project designers, lead inspectors, lead risk assessors,  
259.31 and lead sampling technicians. The commissioner shall also adopt rules requiring  
259.32 certification of firms that perform regulated lead work. The commissioner shall require  
259.33 periodic renewal of licenses and certificates and shall establish the renewal periods.

259.34 Subd. 4. **Lead training course.** The commissioner shall establish by rule  
259.35 requirements for training course providers and the renewal period for each lead-related  
259.36 training course required for certification or licensure. The commissioner shall establish

260.1 criteria in rules for the content and presentation of training courses intended to qualify  
260.2 trainees for licensure under subdivision 3. The commissioner shall establish criteria in  
260.3 rules for the content and presentation of training courses for lead renovation and lead  
260.4 sampling technicians. ~~Training course permit fees shall be nonrefundable and must be~~  
260.5 ~~submitted with each application in the amount of \$500 for an initial training course, \$250~~  
260.6 ~~for renewal of a permit for an initial training course, \$250 for a refresher training course,~~  
260.7 ~~and \$125 for renewal of a permit of a refresher training course.~~

260.8 Subd. 5. **Variances.** In adopting the rules required under this section, the  
260.9 commissioner shall provide variance procedures for any provision in rules adopted under  
260.10 this section, except for the numerical standards for the concentrations of lead in paint,  
260.11 dust, bare soil, and drinking water. A variance shall be considered only according to the  
260.12 procedures and criteria in Minnesota Rules, parts 4717.7000 to 4717.7050.

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

260.14 Sec. 32. **[144.999] LIFE-SAVING ALLERGY MEDICATION.**

260.15 **Subdivision 1. Definitions.** (a) For purposes of this section, the following terms  
260.16 have the meanings given.

260.17 (b) "Administer" means the direct application of an epinephrine auto-injector to  
260.18 the body of an individual.

260.19 (c) "Authorized entity" means entities that fall in the categories of recreation camps,  
260.20 colleges and universities, preschools and daycares, and any other category of entities or  
260.21 organizations that the commissioner authorizes to obtain and administer epinephrine  
260.22 auto-injectors without a prescription. This definition does not include a school covered  
260.23 under section 121A.2207.

260.24 (d) "Commissioner" means the commissioner of health.

260.25 (e) "Epinephrine auto-injector" means a single-use device used for the automatic  
260.26 injection of a premeasured dose of epinephrine into the human body.

260.27 (f) "Provide" means to supply one or more epinephrine auto-injectors to an  
260.28 individual or the individual's parent, legal guardian, or caretaker.

260.29 Subd. 2. **Commissioner duties.** The commissioner may identify additional  
260.30 categories of entities or organizations to be authorized entities if the commissioner  
260.31 determines that individuals may come in contact with allergens capable of causing  
260.32 anaphylaxis. Beginning July 1, 2016, the commissioner may annually review the  
260.33 categories of authorized entities and may authorize additional categories of authorized  
260.34 entities as the commissioner deems appropriate. The commissioner may contract with a  
260.35 vendor to perform the review and identification of authorized entities.

261.1 Subd. 3. **Obtaining and storing epinephrine auto-injectors.** (a) Notwithstanding  
261.2 section 151.37, an authorized entity may obtain and possess epinephrine auto-injectors  
261.3 to be provided or administered to an individual if, in good faith, an owner, manager,  
261.4 employee, or agent of an authorized entity believes that the individual is experiencing  
261.5 anaphylaxis regardless of whether the individual has a prescription for an epinephrine  
261.6 auto-injector. The administration of an epinephrine auto-injector in accordance with  
261.7 this section is not the practice of medicine.

261.8 (b) An authorized entity may obtain epinephrine auto-injectors from pharmacies  
261.9 licensed as wholesale drug distributors pursuant to section 151.47. Prior to obtaining an  
261.10 epinephrine auto-injector, an owner, manager, or authorized agent of the entity must  
261.11 present to the pharmacy a valid certificate of training obtained pursuant to subdivision 5.

261.12 (c) An authorized entity shall store epinephrine auto-injectors in a location readily  
261.13 accessible in an emergency and in accordance with the epinephrine auto-injector's  
261.14 instructions for use and any additional requirements that may be established by the  
261.15 commissioner. An authorized entity shall designate employees or agents who have  
261.16 completed the training program required under subdivision 5 to be responsible for the  
261.17 storage, maintenance, and control of epinephrine auto-injectors obtained and possessed  
261.18 by the authorized entity.

261.19 Subd. 4. **Use of epinephrine auto-injectors.** (a) An owner, manager, employee, or  
261.20 agent of an authorized entity who has completed the training required under subdivision 5  
261.21 may:

261.22 (1) provide an epinephrine auto-injector for immediate administration to an  
261.23 individual or the individual's parent, legal guardian, or caregiver if the owner, manager,  
261.24 employee, or agent believes, in good faith, the individual is experiencing anaphylaxis,  
261.25 regardless of whether the individual has a prescription for an epinephrine auto-injector or  
261.26 has previously been diagnosed with an allergy; or

261.27 (2) administer an epinephrine auto-injector to an individual who the owner, manager,  
261.28 employee, or agent believes, in good faith, is experiencing anaphylaxis, regardless of  
261.29 whether the individual has a prescription for an epinephrine auto-injector or has previously  
261.30 been diagnosed with an allergy.

261.31 (b) Nothing in this section shall be construed to require any authorized entity to  
261.32 maintain a stock of epinephrine auto-injectors.

261.33 Subd. 5. **Training.** (a) In order to use an epinephrine auto-injector as authorized  
261.34 under subdivision 4, an individual must complete, every two years, an anaphylaxis training  
261.35 program conducted by a nationally recognized organization experienced in training  
261.36 laypersons in emergency health treatment, a statewide organization with experience

262.1 providing training on allergies and anaphylaxis under the supervision of board-certified  
262.2 allergy medical advisors, or an entity or individual approved by the commissioner to  
262.3 provide an anaphylaxis training program. The commissioner may approve specific entities  
262.4 or individuals to conduct the training program or may approve categories of entities or  
262.5 individuals to conduct the training program. Training may be conducted online or in  
262.6 person and, at a minimum, must cover:

262.7 (1) how to recognize signs and symptoms of severe allergic reactions, including  
262.8 anaphylaxis;

262.9 (2) standards and procedures for the storage and administration of an epinephrine  
262.10 auto-injector; and

262.11 (3) emergency follow-up procedures.

262.12 (b) The entity or individual conducting the training shall issue a certificate to each  
262.13 person who successfully completes the anaphylaxis training program. The commissioner  
262.14 may develop, approve, and disseminate a standard certificate of completion. The  
262.15 certificate of completion shall be valid for two years from the date issued.

262.16 Subd. 6. **Good samaritan protections.** Any act or omission taken pursuant to  
262.17 this section by an authorized entity that possesses and makes available epinephrine  
262.18 auto-injectors and its employees or agents, a pharmacy or manufacturer that dispenses  
262.19 epinephrine auto-injectors to an authorized entity, or an individual or entity that conducts  
262.20 the training described in subdivision 5 is considered "emergency care, advice, or  
262.21 assistance" under section 604A.01.

262.22 Sec. 33. Minnesota Statutes 2014, section 144A.70, subdivision 6, is amended to read:

262.23 Subd. 6. **Supplemental nursing services agency.** "Supplemental nursing services  
262.24 agency" means a person, firm, corporation, partnership, or association engaged for hire  
262.25 in the business of providing or procuring temporary employment in health care facilities  
262.26 for nurses, nursing assistants, nurse aides, ~~and orderlies,~~ and other licensed health  
262.27 professionals. Supplemental nursing services agency does not include an individual who  
262.28 only engages in providing the individual's services on a temporary basis to health care  
262.29 facilities. Supplemental nursing services agency does not include a professional home  
262.30 care agency licensed as a ~~Class A provider~~ under section ~~144A.46~~ and rules adopted  
262.31 ~~thereunder~~ 144A.471 that only provides staff to other home care providers.

262.32 Sec. 34. Minnesota Statutes 2014, section 144A.70, is amended by adding a  
262.33 subdivision to read:

263.1 Subd. 7. **Oversight.** The commissioner is responsible for the oversight of  
 263.2 supplemental nursing services agencies through annual unannounced surveys, complaint  
 263.3 investigations under sections 144A.51 to 144A.53, and other actions necessary to ensure  
 263.4 compliance with sections 144A.70 to 144A.74.

263.5 Sec. 35. Minnesota Statutes 2014, section 144A.71, is amended to read:

263.6 **144A.71 SUPPLEMENTAL NURSING SERVICES AGENCY**  
 263.7 **REGISTRATION.**

263.8 Subdivision 1. **Duty to register.** A person who operates a supplemental nursing  
 263.9 services agency shall register ~~the agency~~ annually with the commissioner. Each separate  
 263.10 location of the business of a supplemental nursing services agency shall register the agency  
 263.11 with the commissioner. Each separate location of the business of a supplemental nursing  
 263.12 services agency shall have a separate registration. Fees collected under this section shall be  
 263.13 deposited in the state treasury and credited to the state government special revenue fund.

263.14 Subd. 2. **Application information and fee.** The commissioner shall establish forms  
 263.15 and procedures for processing each supplemental nursing services agency registration  
 263.16 application. An application for a supplemental nursing services agency registration must  
 263.17 include at least the following:

263.18 (1) the names and addresses of the owner or owners of the supplemental nursing  
 263.19 services agency;

263.20 (2) if the owner is a corporation, copies of its articles of incorporation and current  
 263.21 bylaws, together with the names and addresses of its officers and directors;

263.22 (3) satisfactory proof of compliance with section 144A.72, subdivision 1, clauses  
 263.23 (5) to (7);

263.24 (4) any other relevant information that the commissioner determines is necessary  
 263.25 to properly evaluate an application for registration; ~~and~~

263.26 (5) ~~the annual registration fee for a supplemental nursing services agency, which~~  
 263.27 ~~is \$891;~~ a policy and procedure that describes how the supplemental nursing services  
 263.28 agency's records will be immediately available at all times to the commissioner; and

263.29 (6) a registration fee of \$2,035.

263.30 If a supplemental nursing services agency fails to provide the items in this  
 263.31 subdivision to the department, the commissioner shall immediately suspend or refuse to  
 263.32 issue the supplemental nursing services agency registration. The supplemental nursing  
 263.33 services agency may appeal the commissioner's findings according to section 144A.475,  
 263.34 subdivisions 3a and 7, except that the hearing must be conducted by an administrative law  
 263.35 judge within 60 calendar days of the request for hearing assignment.

264.1 Subd. 3. **Registration not transferable.** A registration issued by the commissioner  
264.2 according to this section is effective for a period of one year from the date of its issuance  
264.3 unless the registration is revoked or suspended under section 144A.72, subdivision 2, or  
264.4 unless the supplemental nursing services agency is sold or ownership or management  
264.5 is transferred. When a supplemental nursing services agency is sold or ownership or  
264.6 management is transferred, the registration of the agency must be voided and the new  
264.7 owner or operator may apply for a new registration.

264.8 Sec. 36. Minnesota Statutes 2014, section 144A.72, is amended to read:

264.9 **144A.72 REGISTRATION REQUIREMENTS; PENALTIES.**

264.10 Subdivision 1. **Minimum criteria.** (a) The commissioner shall require that, as a  
264.11 condition of registration:

264.12 (1) the supplemental nursing services agency shall document that each temporary  
264.13 employee provided to health care facilities currently meets the minimum licensing, training,  
264.14 and continuing education standards for the position in which the employee will be working;

264.15 (2) the supplemental nursing services agency shall comply with all pertinent  
264.16 requirements relating to the health and other qualifications of personnel employed in  
264.17 health care facilities;

264.18 (3) the supplemental nursing services agency must not restrict in any manner the  
264.19 employment opportunities of its employees;

264.20 (4) the supplemental nursing services agency shall carry medical malpractice  
264.21 insurance to insure against the loss, damage, or expense incident to a claim arising out  
264.22 of the death or injury of any person as the result of negligence or malpractice in the  
264.23 provision of health care services by the supplemental nursing services agency or by any  
264.24 employee of the agency;

264.25 (5) the supplemental nursing services agency shall carry an employee dishonesty  
264.26 bond in the amount of \$10,000;

264.27 (6) the supplemental nursing services agency shall maintain insurance coverage  
264.28 for workers' compensation for all nurses, nursing assistants, nurse aides, and orderlies  
264.29 provided or procured by the agency;

264.30 (7) the supplemental nursing services agency shall file with the commissioner of  
264.31 revenue: (i) the name and address of the bank, savings bank, or savings association  
264.32 in which the supplemental nursing services agency deposits all employee income tax  
264.33 withholdings; and (ii) the name and address of any nurse, nursing assistant, nurse aide, or  
264.34 orderly whose income is derived from placement by the agency, if the agency purports  
264.35 the income is not subject to withholding;



265.1 (8) the supplemental nursing services agency must not, in any contract with any  
265.2 employee or health care facility, require the payment of liquidated damages, employment  
265.3 fees, or other compensation should the employee be hired as a permanent employee of a  
265.4 health care facility; ~~and~~

265.5 (9) the supplemental nursing services agency shall document that each temporary  
265.6 employee provided to health care facilities is an employee of the agency and is not  
265.7 an independent contractor; and

265.8 (10) the supplemental nursing services agency shall retain all records for five  
265.9 calendar years. All records of the supplemental nursing services agency must be  
265.10 immediately available to the department.

265.11 (b) In order to retain registration, the supplemental nursing services agency must  
265.12 provide services to a health care facility during the year preceding the supplemental  
265.13 nursing services agency's registration renewal date.

265.14 Subd. 2. **Penalties.** ~~A pattern of~~ Failure to comply with this section shall subject  
265.15 the supplemental nursing services agency to revocation or nonrenewal of its registration.  
265.16 Violations of section 144A.74 are subject to a fine equal to 200 percent of the amount  
265.17 billed or received in excess of the maximum permitted under that section.

265.18 Subd. 3. **Revocation.** Notwithstanding subdivision 2, the registration of a  
265.19 supplemental nursing services agency that knowingly supplies to a health care facility a  
265.20 person with an illegally or fraudulently obtained or issued diploma, registration, license,  
265.21 certificate, or background study shall be revoked by the commissioner. The commissioner  
265.22 shall notify the supplemental nursing services agency 15 days in advance of the date  
265.23 of revocation.

265.24 Subd. 4. **Hearing.** (a) No supplemental nursing services agency's registration  
265.25 may be revoked without a hearing held as a contested case in accordance with ~~chapter~~  
265.26 ~~14. The hearing must commence within 60 days after the proceedings are initiated~~  
265.27 section 144A.475, subdivisions 3a and 7, except the hearing must be conducted by an  
265.28 administrative law judge within 60 calendar days of the request for assignment.

265.29 (b) If a controlling person has been notified by the commissioner of health that the  
265.30 supplemental nursing services agency will not receive an initial registration or that a  
265.31 renewal of the registration has been denied, the controlling person or a legal representative  
265.32 on behalf of the supplemental nursing services agency may request and receive a hearing  
265.33 on the denial. ~~This~~ The hearing shall be held as a contested case in accordance with  
265.34 ~~chapter 14~~ a contested case in accordance with section 144A.475, subdivisions 3a and 7,  
265.35 except the hearing must be conducted by an administrative law judge within 60 calendar  
265.36 days of the request for assignment.

266.1 Subd. 5. **Period of ineligibility.** (a) The controlling person of a supplemental  
 266.2 nursing services agency whose registration has not been renewed or has been revoked  
 266.3 because of noncompliance with the provisions of sections 144A.70 to 144A.74 shall not  
 266.4 be eligible to apply for nor will be granted a registration for five years following the  
 266.5 effective date of the nonrenewal or revocation.

266.6 (b) The commissioner shall not issue or renew a registration to a supplemental  
 266.7 nursing services agency if a controlling person includes any individual or entity who was  
 266.8 a controlling person of a supplemental nursing services agency whose registration was  
 266.9 not renewed or was revoked as described in paragraph (a) for five years following the  
 266.10 effective date of nonrenewal or revocation.

266.11 Sec. 37. Minnesota Statutes 2014, section 144A.73, is amended to read:

266.12 **144A.73 COMPLAINT SYSTEM.**

266.13 The commissioner shall establish a system for reporting complaints against a  
 266.14 supplemental nursing services agency or its employees. Complaints may be made by  
 266.15 any member of the public. ~~Written complaints must be forwarded to the employer of~~  
 266.16 ~~each person against whom a complaint is made. The employer shall promptly report to~~  
 266.17 ~~the commissioner any corrective action taken~~ Complaints against a supplemental nursing  
 266.18 services agency shall be investigated by the Office of Health Facility Complaints under  
 266.19 Minnesota Statutes, sections 144A.51 to 144A.53.

266.20 Sec. 38. Minnesota Statutes 2014, section 144D.01, is amended by adding a  
 266.21 subdivision to read:

266.22 Subd. 3a. **Direct-care staff.** "Direct-care staff" means staff and employees who  
 266.23 provide home care services listed in section 144A.471, subdivisions 6 and 7.

266.24 Sec. 39. **[144D.066] ENFORCEMENT OF DEMENTIA CARE TRAINING**  
 266.25 **REQUIREMENTS.**

266.26 Subdivision 1. **Enforcement.** (a) The commissioner shall enforce the dementia care  
 266.27 training standards for staff working in housing with services settings and for housing  
 266.28 managers according to clauses (1) to (3):

266.29 (1) for dementia care training requirements in section 144D.065, the commissioner  
 266.30 shall review training records as part of the home care provider survey process for direct  
 266.31 care staff and supervisors of direct care staff, in accordance with section 144A.474. The  
 266.32 commissioner may also request and review training records at any time during the year;

267.1 (2) for dementia care training standards in section 144D.065, the commissioner  
267.2 shall review training records for maintenance, housekeeping, and food service staff and  
267.3 other staff not providing direct care working in housing with services settings as part of  
267.4 the housing with services registration application and renewal application process in  
267.5 accordance with section 144D.03. The commissioner may also request and review training  
267.6 records at any time during the year; and

267.7 (3) for housing managers, the commissioner shall review the statement verifying  
267.8 compliance with the required training described in section 144D.10, paragraph (d),  
267.9 through the housing with services registration application and renewal application process  
267.10 in accordance with section 144D.03. The commissioner may also request and review  
267.11 training records at any time during the year.

267.12 (b) The commissioner shall specify the required forms and what constitutes sufficient  
267.13 training records for the items listed in paragraph (a), clauses (1) to (3).

267.14 Subd. 2. **Fines for noncompliance.** (a) Beginning January 1, 2017, the  
267.15 commissioner may impose a \$200 fine for every staff person required to obtain dementia  
267.16 care training who does not have training records to show compliance. For violations of  
267.17 subdivision 1, paragraph (a), clause (1), the fine will be imposed upon the home care  
267.18 provider, and may be appealed under the contested case procedure in section 144A.475,  
267.19 subdivisions 3a, 4, and 7. For violations of subdivision 1, paragraph (a), clauses (2) and  
267.20 (3), the fine will be imposed on the housing with services registrant and may be appealed  
267.21 under the contested case procedure in section 144A.475, subdivisions 3a, 4, and 7. Prior  
267.22 to imposing the fine, the commissioner must allow two weeks for staff to complete the  
267.23 required training. Fines collected under this section shall be deposited in the state treasury  
267.24 and credited to the state government special revenue fund.

267.25 (b) The housing with services registrant and home care provider must allow  
267.26 for the required training as part of employee and staff duties. Imposition of a fine  
267.27 by the commissioner does not negate the need for the required training. Continued  
267.28 noncompliance with the requirements of sections 144D.065 and 144D.10 may result in  
267.29 revocation or nonrenewal of the housing with services registration or home care license.  
267.30 The commissioner shall make public the list of all housing with services establishments  
267.31 that have complied with the training requirements.

267.32 Subd. 3. **Technical assistance.** From January 1, 2016, to December 31, 2016,  
267.33 the commissioner shall provide technical assistance instead of imposing fines for  
267.34 noncompliance with the training requirements. During the year of technical assistance,  
267.35 the commissioner shall review the training records to determine if the records meet the

268.1 requirements and inform the home care provider. The commissioner shall also provide  
 268.2 information about available training resources.

268.3 Sec. 40. Minnesota Statutes 2014, section 144E.50, is amended to read:

268.4 **144E.50 EMERGENCY MEDICAL SERVICES FUND.**

268.5 Subdivision 1. **Citation.** This section is the "Minnesota Emergency Medical  
 268.6 Services System Support Act."

268.7 Subd. 2. **Establishment and purpose.** In order to develop, maintain, and  
 268.8 improve regional emergency medical services systems, the ~~Emergency Medical Services~~  
 268.9 ~~Regulatory Board~~ commissioner shall establish an emergency medical services system  
 268.10 fund. The fund shall be used for the general purposes of promoting systematic,  
 268.11 cost-effective delivery of emergency medical and trauma care throughout the state;  
 268.12 identifying common local, regional, and state emergency medical system needs and  
 268.13 providing assistance in addressing those needs; providing discretionary grants for  
 268.14 emergency medical service projects with potential regionwide significance; providing for  
 268.15 public education about emergency medical care; promoting the exchange of emergency  
 268.16 medical care information; ensuring the ongoing coordination of regional emergency  
 268.17 medical services systems; and ~~establishing and maintaining~~ supporting training standards  
 268.18 to ensure consistent quality of emergency medical services throughout the state.

268.19 Subd. 3. **Definition Definitions.** For purposes of this section, "~~board~~" ~~means the~~  
 268.20 ~~Emergency Medical Services Regulatory Board~~ the following terms have the meanings  
 268.21 given them.

268.22 (a) "Commissioner" means the commissioner of health.

268.23 (b) "Grantee" means a public or private entity that receives a regional grant.

268.24 (c) "Regional emergency medical services programs" include the following regional  
 268.25 locations:

268.26 (1) Region One, consisting of the counties of Beltrami, Clearwater, Hubbard,  
 268.27 Kittson, Lake of the Woods, Mahnomen, Marshall, Norman, Pennington, Polk, Red  
 268.28 Lake, and Roseau;

268.29 (2) Region Two, consisting of the counties of Becker, Clay, Douglas, Grant, Otter  
 268.30 Tail, Pope, Stevens, Traverse, and Wilkin;

268.31 (3) Region Three, consisting of the counties of Aitkin, Carlton, Cook, Itasca,  
 268.32 Koochiching, Lake, and St. Louis;

268.33 (4) Region Four, consisting of the counties of Benton, Cass, Crow Wing, Kanabec,  
 268.34 Mille Lacs, Morrison, Pine, Sherburne, Stearns, Todd, Wadena, and Wright;

269.1 (5) Region Five, consisting of the counties of Big Stone, Chippewa, Cottonwood,  
 269.2 Jackson, Kandiyohi, Lac Qui Parle, Lincoln, Lyon, McLeod, Meeker, Murray, Nobles,  
 269.3 Pipestone, Redwood, Renville, Rock, Swift, and Yellow Medicine;

269.4 (6) Region Six, consisting of the counties of Blue Earth, Brown, Faribault, Le Sueur,  
 269.5 Martin, Nicollet, Sibley, Waseca, and Watonwan;

269.6 (7) Region Seven, consisting of the counties of Dodge, Fillmore, Freeborn,  
 269.7 Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, and Winona; and

269.8 (8) Region Eight, consisting of the counties of Anoka, Carver, Chisago, Dakota,  
 269.9 Hennepin, Isanti, Ramsey, Scott, and Washington.

269.10 (d) "Regional emergency medical services program grants" or "regional grants"  
 269.11 means grant funds overseen and distributed according to subdivisions 4 and 5, and section  
 269.12 169.686, subdivision 3.

269.13 (e) "Time-sensitive syndromes" means medical conditions for which time is critical  
 269.14 to the patient's survival and health outcome.

269.15 ~~Subd. 4. **Use and restrictions.** Designated regional emergency medical services~~  
 269.16 ~~systems (a) Grantees may use regional emergency medical services system program~~  
 269.17 ~~funds to support local and regional emergency medical services as determined within the~~  
 269.18 ~~region, with particular emphasis given to supporting and improving emergency trauma~~  
 269.19 ~~and cardiac care and training care of time-sensitive syndromes. No part of a region's~~  
 269.20 ~~share of the fund grant funds may be used to directly subsidize any ambulance service~~  
 269.21 ~~operations or rescue service operations or to purchase any vehicles or parts of vehicles for~~  
 269.22 ~~an ambulance service or a rescue service.~~

269.23 (b) Each grantee shall provide oversight of regional emergency medical services  
 269.24 programs by establishing an oversight committee consisting of representatives appointed  
 269.25 by the county board of each of the counties in the region and representatives appointed by  
 269.26 local emergency medical services organizations.

269.27 ~~Subd. 5. **Distribution.** Money from the fund shall be distributed according to~~  
 269.28 ~~this subdivision. Ninety-five percent of the fund shall be distributed annually on a~~  
 269.29 ~~contract for services basis with each of the eight regional emergency medical services~~  
 269.30 ~~systems designated by the board. The systems shall be governed by a body consisting of~~  
 269.31 ~~appointed representatives from each of the counties in that region and shall also include~~  
 269.32 ~~representatives from emergency medical services organizations. The board shall contract~~  
 269.33 ~~with a regional entity only if the contract proposal satisfactorily addresses proposed~~  
 269.34 ~~emergency medical services activities in~~ The commissioner may award up to eight  
 269.35 regional emergency medical services program grants. The commissioner shall offer grant  
 269.36 agreements to one applicant per region, following the review of grant applications and

270.1 approval of an acceptable grant application. Grant applications must satisfactorily address  
270.2 the following areas: personnel training, transportation coordination, public safety agency  
270.3 cooperation, communications systems maintenance and development, public involvement,  
270.4 health care facilities involvement, and system management. If each of the regional  
270.5 emergency medical services systems submits a satisfactory contract proposal, then this part  
270.6 of the Funds from the emergency medical services fund shall be distributed evenly among  
270.7 the regions grantees. If one or more of the regions applicants does not contract apply for  
270.8 the full amount of its even share or if its proposal application is unsatisfactory, then the  
270.9 board commissioner may reallocate the unused funds to the remaining regions grantees on  
270.10 a pro rata basis. Five percent of the fund shall be used by the board to support regionwide  
270.11 reporting systems and to provide other regional administration and technical assistance.

270.12 ~~Subd. 6. **Audits.** (a) Each regional emergency medical services board designated by~~  
270.13 ~~the board shall be audited either annually or biennially by an independent auditor who~~  
270.14 ~~is either a state or local government auditor or a certified public accountant who meets~~  
270.15 ~~the independence standards specified by the General Accounting Office for audits of~~  
270.16 ~~governmental organizations, programs, activities, and functions. The audit shall cover~~  
270.17 ~~all funds received by the regional board, including but not limited to, funds appropriated~~  
270.18 ~~under this section, section 144E.52, and section 169.686, subdivision 3. Expenses~~  
270.19 ~~associated with the audit are the responsibility of the regional board.~~

270.20 ~~(b) A biennial audit specified in paragraph (a) shall be performed within 60 days~~  
270.21 ~~following the close of the biennium. Copies of the audit and any accompanying materials~~  
270.22 ~~shall be filed by October 1 of each odd-numbered year, beginning in 1999, with the board,~~  
270.23 ~~the legislative auditor, and the state auditor.~~

270.24 ~~(c) An annual audit specified in paragraph (a) shall be performed within 120 days~~  
270.25 ~~following the close of the regional emergency medical services board's fiscal year. Copies~~  
270.26 ~~of the audit and any accompanying materials shall be filed within 150 days following the~~  
270.27 ~~close of the regional emergency medical services board's fiscal year, beginning in the year~~  
270.28 ~~2000, with the board, the legislative auditor, and the state auditor.~~

270.29 ~~(d) If the audit is not conducted as required in paragraph (a) or copies filed as~~  
270.30 ~~required in paragraph (b) or (c), or if the audit determines that funds were not spent in~~  
270.31 ~~accordance with this chapter, the board shall immediately reduce funding to the regional~~  
270.32 ~~emergency medical services board as follows:~~

270.33 ~~(1) if an audit was not conducted or if an audit was conducted but copies were not~~  
270.34 ~~provided as required, funding shall be reduced by up to 100 percent; and~~

271.1 ~~(2) if an audit was conducted and copies provided, and the audit identifies~~  
 271.2 ~~expenditures made that are not in compliance with this chapter, funding shall be reduced~~  
 271.3 ~~by the amount in question plus ten percent.~~

271.4 ~~A funding reduction under this paragraph is effective for the fiscal year in which the~~  
 271.5 ~~reduction is taken and the following fiscal year.~~

271.6 ~~(e) The board shall distribute any funds withheld from a regional board under~~  
 271.7 ~~paragraph (d) to the remaining regional boards on a pro rata basis.~~

271.8 Sec. 41. Minnesota Statutes 2014, section 144F.01, subdivision 5, is amended to read:

271.9 Subd. 5. **Use of levy proceeds.** The proceeds of property taxes levied under this  
 271.10 section must be used to support the providing of out-of-hospital emergency medical  
 271.11 services including, but not limited to, first responder or rescue squads recognized by  
 271.12 the district, ambulance services licensed under chapter 144E and recognized by the  
 271.13 district, medical control functions set out in chapter 144E, communications equipment and  
 271.14 systems, and programs of regional emergency medical services ~~authorized by regional~~  
 271.15 ~~boards described in section 144E.52.~~

271.16 Sec. 42. Minnesota Statutes 2014, section 145.928, is amended by adding a subdivision  
 271.17 to read:

271.18 Subd. 15. **Promising strategies.** For all grants awarded under this section, the  
 271.19 commissioner shall consider applicants that present evidence of a promising strategy to  
 271.20 accomplish the applicant's objective. A promising strategy shall be given the same weight  
 271.21 as a research or evidence-based strategy.

271.22 Sec. 43. Minnesota Statutes 2014, section 145A.131, subdivision 1, is amended to read:

271.23 Subdivision 1. **Funding formula for community health boards.** (a) Base funding  
 271.24 for each community health board eligible for a local public health grant under section  
 271.25 145A.03, subdivision 7, shall be determined by each community health board's fiscal year  
 271.26 2003 allocations, prior to unallotment, for the following grant programs: community  
 271.27 health services subsidy; state and federal maternal and child health special projects grants;  
 271.28 family home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants;  
 271.29 and available women, infants, and children grant funds in fiscal year 2003, prior to  
 271.30 unallotment, distributed based on the proportion of WIC participants served in fiscal year  
 271.31 2003 within the CHS service area.

271.32 (b) Base funding for a community health board eligible for a local public health  
 271.33 grant under section 145A.03, subdivision 7, as determined in paragraph (a), shall be

272.1 adjusted by the percentage difference between the base, as calculated in paragraph (a),  
272.2 and the funding available for the local public health grant.

272.3 (c) Multicounty or multicity community health boards shall receive a local  
272.4 partnership base of up to \$5,000 per year for each county or city in the case of a multicity  
272.5 community health board included in the community health board.

272.6 (d) The State Community Health Advisory Committee may recommend a formula  
272.7 to the commissioner to use in distributing ~~state and federal~~ funds to community health  
272.8 boards ~~organized and operating under sections 145A.03 to 145A.131 to achieve locally~~  
272.9 ~~identified priorities under section 145A.04, subdivision 1a, for use in distributing funds to~~  
272.10 ~~community health boards beginning January 1, 2006, and thereafter.~~

272.11 (e) Notwithstanding any adjustment in paragraph (b), community health boards, all  
272.12 or a portion of which are located outside of the counties of Anoka, Chisago, Carver,  
272.13 Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright, are eligible  
272.14 to receive an increase equal to ten percent of the grant award to the community health  
272.15 board under paragraph (a) starting July 1, 2015. The increase in calendar year 2015 shall  
272.16 be prorated for the last six months of the year. For calendar years beginning on or after  
272.17 January 1, 2016, the amount distributed under this paragraph shall be adjusted each year  
272.18 based on available funding and the number of eligible community health boards.

272.19 Sec. 44. Minnesota Statutes 2014, section 149A.20, subdivision 5, is amended to read:

272.20 Subd. 5. **Examinations.** After having met the educational requirements of  
272.21 subdivision 4, a person must attain a passing score on the National Board Examination  
272.22 administered by the Conference of Funeral Service Examining Boards of the United  
272.23 States, Inc. or any other examination that, in the determination of the commissioner,  
272.24 adequately and accurately assesses the knowledge and skills required to practice  
272.25 mortuary science. In addition, a person must attain a passing score on the state licensing  
272.26 examination administered by or on behalf of the commissioner. The state examination  
272.27 shall encompass the laws and rules of Minnesota that pertain to the practice of mortuary  
272.28 science. The commissioner shall make available copies of all pertinent laws and rules  
272.29 prior to administration of the state licensing examination. If a passing score is not attained  
272.30 on the state examination, the individual must wait two weeks before they can retake  
272.31 the examination.

272.32 Sec. 45. Minnesota Statutes 2014, section 149A.20, subdivision 6, is amended to read:

272.33 Subd. 6. **Internship.** (a) A person who attains a passing score on both examinations  
272.34 in subdivision 5 must complete a registered internship under the direct supervision of an



273.1 individual currently licensed to practice mortuary science in Minnesota. Interns must file  
273.2 with the commissioner:

273.3 (1) the appropriate fee; and

273.4 (2) a registration form indicating the name and home address of the intern, the  
273.5 date the internship begins, and the name, license number, and business address of the  
273.6 supervising mortuary science licensee.

273.7 (b) Any changes in information provided in the registration must be immediately  
273.8 reported to the commissioner. The internship shall be a minimum of ~~one calendar year~~  
273.9 ~~and a maximum of three calendar years in duration;~~ 2,080 hours to be completed within a  
273.10 three-year period, however, the commissioner may waive up to ~~three months~~ 520 hours of  
273.11 the internship time requirement upon satisfactory completion of a clinical or practicum  
273.12 in mortuary science administered through the program of mortuary science of the  
273.13 University of Minnesota or a substantially similar program approved by the commissioner.  
273.14 Registrations must be renewed on an annual basis if they exceed one calendar year. During  
273.15 the internship period, the intern must be under the direct supervision of a person holding a  
273.16 current license to practice mortuary science in Minnesota. An intern may be registered  
273.17 under only one licensee at any given time and may be directed and supervised only by  
273.18 the registered licensee. The registered licensee shall have only one intern registered at  
273.19 any given time. The commissioner shall issue to each registered intern a registration  
273.20 permit that must be displayed with the other establishment and practice licenses. While  
273.21 under the direct supervision of the licensee, the intern must ~~actively participate in the~~  
273.22 ~~embalming of at least 25 dead human bodies and in the arrangements for and direction of~~  
273.23 ~~at least 25 funerals~~ complete 25 case reports in each of the following areas: embalming,  
273.24 funeral arrangements, and services. Case reports, on forms provided by the commissioner,  
273.25 shall be completed by the intern, ~~signed by the supervising licensee,~~ and filed with the  
273.26 commissioner ~~for at least 25 embalmings and funerals in which the intern participates prior~~  
273.27 ~~to the completion of the internship.~~ Information contained in these reports that identifies  
273.28 the subject or the family of the subject embalmed or the subject or the family of the subject  
273.29 of the funeral shall be classified as licensing data under section 13.41, subdivision 2.

273.30 Sec. 46. Minnesota Statutes 2014, section 149A.40, subdivision 11, is amended to read:

273.31 Subd. 11. **Continuing education.** The commissioner ~~may~~ shall require 15  
273.32 continuing education hours for renewal of a license to practice mortuary science. Nine  
273.33 of the hours must be in the following areas: body preparation, care, or handling, 3 CE  
273.34 hours; professional practices, 3 CE hours; regulation and ethics, 3 CE hours. Continuing  
273.35 education hours shall be reported to the commissioner every other year based on the

274.1 licensee's license number. Licensees whose license ends in an odd number must report CE  
 274.2 hours at renewal time every odd year. If a licensee's license ends in an even number, the  
 274.3 licensee must report the licensee's CE hours at renewal time every even year.

274.4 Sec. 47. Minnesota Statutes 2014, section 149A.65, is amended to read:

274.5 **149A.65 FEES.**

274.6 Subdivision 1. **Generally.** This section establishes the fees for registrations,  
 274.7 examinations, initial and renewal licenses, and late fees authorized under the provisions  
 274.8 of this chapter.

274.9 Subd. 2. **Mortuary science fees.** Fees for mortuary science are:

274.10 (1) ~~\$50~~ \$75 for the initial and renewal registration of a mortuary science intern;

274.11 (2) ~~\$100~~ \$125 for the mortuary science examination;

274.12 (3) ~~\$125~~ \$200 for issuance of initial and renewal mortuary science licenses;

274.13 (4) ~~\$25~~ \$100 late fee charge for a license renewal; and

274.14 (5) ~~\$200~~ \$250 for issuing a mortuary science license by endorsement.

274.15 Subd. 3. **Funeral directors.** The license renewal fee for funeral directors is ~~\$125~~

274.16 \$200. The late fee charge for a license renewal is ~~\$25~~ \$100.

274.17 Subd. 4. **Funeral establishments.** The initial and renewal fee for funeral  
 274.18 establishments is ~~\$300~~ \$425. The late fee charge for a license renewal is ~~\$25~~ \$100.

274.19 Subd. 5. **Crematories.** The initial and renewal fee for a crematory is ~~\$300~~ \$425.

274.20 The late fee charge for a license renewal is ~~\$25~~ \$100.

274.21 Subd. 6. **Alkaline hydrolysis facilities.** The initial and renewal fee for an alkaline  
 274.22 hydrolysis facility is ~~\$300~~ \$425. The late fee charge for a license renewal is ~~\$25~~ \$100.

274.23 Subd. 7. **State government special revenue fund.** Fees collected by the  
 274.24 commissioner under this section must be deposited in the state treasury and credited to  
 274.25 the state government special revenue fund.

274.26 Sec. 48. Minnesota Statutes 2014, section 149A.92, subdivision 1, is amended to read:

274.27 Subdivision 1. **Exemption Establishment update.** ~~All funeral establishments~~  
 274.28 ~~having a preparation and embalming room that has not been used for the preparation or~~  
 274.29 ~~embalming of a dead human body in the 12 calendar months prior to July 1, 1997, are~~  
 274.30 ~~exempt from the minimum requirements in subdivisions 2 to 6, except as provided in this~~  
 274.31 ~~section.~~ At the time that ownership of a funeral establishment changes, the physical  
 274.32 location of the establishment changes, or the building housing the funeral establishment or  
 274.33 business space of the establishment is remodeled the existing preparation and embalming

275.1 room must be brought into compliance with the minimum standards in this section and in  
275.2 accordance with subdivision 11.

275.3 Sec. 49. Minnesota Statutes 2014, section 149A.97, subdivision 7, is amended to read:

275.4 Subd. 7. **Reports to commissioner.** Every funeral provider lawfully doing business  
275.5 in Minnesota that accepts funds under subdivision 2 must make a complete annual report  
275.6 to the commissioner. The reports may be on forms provided by the commissioner or  
275.7 substantially similar forms containing, at least, identification and the state of each trust  
275.8 account, including all transactions involving principal and accrued interest, and must be  
275.9 filed by March 31 of the calendar year following the reporting year along with a filing fee  
275.10 of \$25 for each report. Fees shall be paid to the commissioner of management and budget,  
275.11 state of Minnesota, for deposit in the state government special revenue fund in the state  
275.12 treasury. Reports must be signed by an authorized representative of the funeral provider  
275.13 and notarized under oath. All reports to the commissioner shall be reviewed for account  
275.14 inaccuracies or possible violations of this section. If the commissioner has a reasonable  
275.15 belief to suspect that there are account irregularities or possible violations of this section,  
275.16 the commissioner shall report that belief, in a timely manner, to the state auditor or other  
275.17 state agencies as determined by the commissioner. The commissioner may require a  
275.18 funeral provider reporting preneed trust accounts under this section to arrange for and  
275.19 pay an independent third-party auditing firm to complete an audit of the preneed trust  
275.20 accounts every other year. The funeral provider shall report the findings of the audit to the  
275.21 commissioner by March 31 of the calendar year following the reporting year. This report is  
275.22 in addition to the annual report. The commissioner shall also file an annual letter with the  
275.23 state auditor disclosing whether or not any irregularities or possible violations were detected  
275.24 in review of the annual trust fund reports filed by the funeral providers. This letter shall be  
275.25 filed with the state auditor by May 31 of the calendar year following the reporting year.

275.26 Sec. 50. Minnesota Statutes 2014, section 157.16, is amended to read:

275.27 **157.16 LICENSES REQUIRED; FEES.**

275.28 Subdivision 1. **License required annually.** A license is required annually for every  
275.29 person, firm, or corporation engaged in the business of conducting a food and beverage  
275.30 service establishment, youth camp, hotel, motel, lodging establishment, public pool,  
275.31 or resort. Any person wishing to operate a place of business licensed in this section  
275.32 shall first make application, pay the required fee specified in this section, and receive  
275.33 approval for operation, including plan review approval. Special event food stands are  
275.34 not required to submit plans. Nonprofit organizations operating a special event food

276.1 stand with multiple locations at an annual one-day event shall be issued only one license.  
276.2 Application shall be made on forms provided by the commissioner and shall require the  
276.3 applicant to state the full name and address of the owner of the building, structure, or  
276.4 enclosure, the lessee and manager of the food and beverage service establishment, hotel,  
276.5 motel, lodging establishment, public pool, or resort; the name under which the business is  
276.6 to be conducted; and any other information as may be required by the commissioner to  
276.7 complete the application for license.

276.8       Subd. 2. **License renewal.** Initial and renewal licenses for all food and beverage  
276.9 service establishments, youth camps, hotels, motels, lodging establishments, public pools,  
276.10 and resorts shall be issued on an annual basis. Any person who operates a place of business  
276.11 after the expiration date of a license or without having submitted an application and paid  
276.12 the fee shall be deemed to have violated the provisions of this chapter and shall be subject  
276.13 to enforcement action, as provided in the Health Enforcement Consolidation Act, sections  
276.14 144.989 to 144.993. In addition, a penalty of \$60 shall be added to the total of the license  
276.15 fee for any food and beverage service establishment operating without a license as a mobile  
276.16 food unit, a seasonal temporary or seasonal permanent food stand, or a special event food  
276.17 stand, and a penalty of \$120 shall be added to the total of the license fee for all restaurants,  
276.18 food carts, hotels, motels, lodging establishments, youth camps, public pools, and resorts  
276.19 operating without a license for a period of up to 30 days. A late fee of \$360 shall be added  
276.20 to the license fee for establishments operating more than 30 days without a license.

276.21       Subd. 2a. **Food manager certification.** An applicant for certification or certification  
276.22 renewal as a food manager must submit to the commissioner a \$35 nonrefundable  
276.23 certification fee payable to the Department of Health. The commissioner shall issue a  
276.24 duplicate certificate to replace a lost, destroyed, or mutilated certificate if the applicant  
276.25 submits a completed application on a form provided by the commissioner for a duplicate  
276.26 certificate and pays \$20 to the department for the cost of duplication.

276.27       Subd. 3. **Establishment fees; definitions.** (a) The following fees are required  
276.28 for food and beverage service establishments, youth camps, hotels, motels, lodging  
276.29 establishments, public pools, and resorts licensed under this chapter. ~~Food and beverage~~  
276.30 ~~service establishments must pay the highest applicable fee under paragraph (d), clause~~  
276.31 ~~(1), (2), (3), or (4), and establishments serving alcohol must pay the highest applicable~~  
276.32 ~~fee under paragraph (d), clause (6) or (7).~~ The license fee for new operators previously  
276.33 licensed under this chapter for the same calendar year is one-half of the appropriate annual  
276.34 license fee, plus any penalty that may be required. The license fee for operators opening  
276.35 on or after October 1 is one-half of the appropriate annual license fee, plus any penalty  
276.36 that may be required.

277.1 (b) Each food and beverage establishment shall pay the applicable fees specified  
 277.2 in section 15.445.

277.3 ~~(b) (c) All food and beverage service establishments, except special event food~~  
 277.4 ~~stands, and all hotels, motels, lodging establishments, public pools, and resorts shall pay~~  
 277.5 ~~an annual base fee of \$150, except for establishments that paid for a food and beverage~~  
 277.6 ~~establishment license under paragraph (b).~~

277.7 ~~(e) A special event food stand shall pay a flat fee of \$50 annually. "Special event~~  
 277.8 ~~food stand" means a fee category where food is prepared or served in conjunction with~~  
 277.9 ~~celebrations, county fairs, or special events from a special event food stand as defined~~  
 277.10 ~~in section 157.15.~~

277.11 ~~(d) In addition to the base fee in paragraph (b) (c), each food and beverage service~~  
 277.12 ~~establishment, other than a special event food stand and a school concession stand, and~~  
 277.13 ~~each hotel, motel, lodging establishment, public pool, and resort shall pay an additional~~  
 277.14 ~~annual fee for each applicable fee category, additional food service, or required additional~~  
 277.15 ~~inspection specified in this paragraph:~~

277.16 ~~(1) Limited food menu selection, \$60. "Limited food menu selection" means a fee~~  
 277.17 ~~category that provides one or more of the following:~~

277.18 ~~(i) prepackaged food that receives heat treatment and is served in the package;~~

277.19 ~~(ii) frozen pizza that is heated and served;~~

277.20 ~~(iii) a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;~~

277.21 ~~(iv) soft drinks, coffee, or nonalcoholic beverages; or~~

277.22 ~~(v) cleaning for eating, drinking, or cooking utensils, when the only food served~~  
 277.23 ~~is prepared off site.~~

277.24 ~~(2) Small establishment, including boarding establishments, \$120. "Small~~  
 277.25 ~~establishment" means a fee category that has no salad bar and meets one or more of~~  
 277.26 ~~the following:~~

277.27 ~~(i) possesses food service equipment that consists of no more than a deep fat fryer, a~~  
 277.28 ~~grill, two hot holding containers, and one or more microwave ovens;~~

277.29 ~~(ii) serves dipped ice cream or soft serve frozen desserts;~~

277.30 ~~(iii) serves breakfast in an owner-occupied bed and breakfast establishment;~~

277.31 ~~(iv) is a boarding establishment; or~~

277.32 ~~(v) meets the equipment criteria in clause (3), item (i) or (ii), and has a maximum~~  
 277.33 ~~patron seating capacity of not more than 50.~~

277.34 ~~(3) Medium establishment, \$310. "Medium establishment" means a fee category~~  
 277.35 ~~that meets one or more of the following:~~

278.1 ~~(i) possesses food service equipment that includes a range, oven, steam table, salad~~  
278.2 ~~bar, or salad preparation area;~~

278.3 ~~(ii) possesses food service equipment that includes more than one deep fat fryer,~~  
278.4 ~~one grill, or two hot holding containers; or~~

278.5 ~~(iii) is an establishment where food is prepared at one location and served at one or~~  
278.6 ~~more separate locations.~~

278.7 ~~Establishments meeting criteria in clause (2), item (v), are not included in this fee~~  
278.8 ~~category.~~

278.9 ~~(4) Large establishment, \$540. "Large establishment" means either:~~

278.10 ~~(i) a fee category that (A) meets the criteria in clause (3), items (i) or (ii), for a~~  
278.11 ~~medium establishment, (B) seats more than 175 people, and (C) offers the full menu~~  
278.12 ~~selection an average of five or more days a week during the weeks of operation; or~~

278.13 ~~(ii) a fee category that (A) meets the criteria in clause (3), item (iii), for a medium~~  
278.14 ~~establishment, and (B) prepares and serves 500 or more meals per day.~~

278.15 ~~(5) Other food and beverage service, including food carts, mobile food units,~~  
278.16 ~~seasonal temporary food stands, and seasonal permanent food stands, \$60.~~

278.17 ~~(6) Beer or wine table service, \$60. "Beer or wine table service" means a fee~~  
278.18 ~~category where the only alcoholic beverage service is beer or wine, served to customers~~  
278.19 ~~seated at tables.~~

278.20 ~~(7) Alcoholic beverage service, other than beer or wine table service, \$165.~~

278.21 ~~"Alcohol beverage service, other than beer or wine table service" means a fee category~~  
278.22 ~~where alcoholic mixed drinks are served or where beer or wine are served from a bar.~~

278.23 ~~(8) (1) Lodging per sleeping accommodation unit, \$10, including hotels, motels,~~  
278.24 ~~lodging establishments, and resorts, up to a maximum of \$1,000. "Lodging per sleeping~~  
278.25 ~~accommodation unit" means a fee category including the number of guest rooms, cottages,~~  
278.26 ~~or other rental units of a hotel, motel, lodging establishment, or resort; or the number of~~  
278.27 ~~beds in a dormitory.~~

278.28 ~~(9) (2) First public pool, \$325; each additional public pool, \$175. "Public pool"~~  
278.29 ~~means a fee category that has the meaning given in section 144.1222, subdivision 4.~~

278.30 ~~(10) (3) First spa, \$175; each additional spa, \$100. "Spa pool" means a fee category~~  
278.31 ~~that has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.~~

278.32 ~~(11) (4) Private sewer or water, \$60. "Individual private water" means a fee category~~  
278.33 ~~with a water supply other than a community public water supply as defined covered in~~  
278.34 ~~Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an~~  
278.35 ~~individual sewage treatment system which uses subsurface treatment and disposal.~~

279.1 ~~(12) Additional food service, \$150. "Additional food service" means a location at~~  
 279.2 ~~a food service establishment, other than the primary food preparation and service area,~~  
 279.3 ~~used to prepare or serve food to the public. Additional food service does not apply to~~  
 279.4 ~~school concession stands.~~

279.5 ~~(13) Additional inspection fee, \$360. "Additional inspection fee" means a fee to~~  
 279.6 ~~conduct the second inspection each year for elementary and secondary education facility~~  
 279.7 ~~school lunch programs when required by the Richard B. Russell National School Lunch~~  
 279.8 ~~Act.~~

279.9 (e) Youth camps shall pay an annual single fee for food and lodging as follows:

279.10 (1) camps with up to 99 campers, \$325;

279.11 (2) camps with 100 to 199 campers, \$550; and

279.12 (3) camps with 200 or more campers, \$750.

279.13 (f) A youth camp that pays fees under paragraph (b) or (d) is not required to pay  
 279.14 fees under paragraph (e).

279.15 Subd. 3a. Construction plan review. ~~(e) (a)~~ A fee for review of construction plans  
 279.16 must accompany the initial license application for restaurants, hotels, motels, lodging  
 279.17 establishments, resorts, seasonal food stands, and mobile food units. The fee for this  
 279.18 construction plan review is as follows:

279.19	<b>Service Area</b>	<b>Type</b>	<b>Fee</b>
279.20	Food	<del>limited food menu</del> <u>category 1 establishment</u>	\$275
279.21		<del>small</del> <u>category 2 establishment</u>	\$400
279.22		<del>medium</del> <u>category 3 establishment</u>	\$450
279.23		<del>large food</del> <u>category 4 establishment</u>	\$500
279.24		additional food service	\$150
279.25	<del>Transient food service</del>		
279.26	<u>Temporary food establishment</u>		
279.27		food cart	\$250
279.28		seasonal permanent food stand	\$250
279.29		seasonal temporary food stand	\$250
279.30		mobile food unit	\$350
279.31	Alcohol	<del>beer or wine table service</del>	\$150
279.32		<del>alcohol service from bar</del>	\$250
279.33	Lodging	less than 25 rooms	\$375
279.34		25 to less than 100 rooms	\$400
279.35		100 rooms or more	\$500
279.36		less than five cabins	\$350
279.37		five to less than ten cabins	\$400
279.38		ten cabins or more	\$450

279.39 ~~(f) (b)~~ When existing food and beverage service establishments, hotels, motels,  
 279.40 lodging establishments, resorts, seasonal food stands, and mobile food units are

280.1 extensively remodeled, a fee must be submitted with the remodeling plans. The fee for  
280.2 this construction plan review is as follows:

280.3	<b>Service Area</b>	<b>Type</b>	<b>Fee</b>
280.4	Food	<del>limited food menu</del> <u>category 1 establishment</u>	\$250
280.5		<del>small</del> <u>category 2 establishment</u>	\$300
280.6		<del>medium</del> <u>category 3 establishment</u>	\$350
280.7		<del>large food</del> <u>category 4 establishment</u>	\$400
280.8		additional food service	\$150
280.9	<del>Transient food service</del>		
280.10	<u>Temporary food</u>		
280.11	<u>establishment</u>	food cart	\$250
280.12		seasonal permanent food stand	\$250
280.13		seasonal temporary food stand	\$250
280.14		mobile food unit	\$250
280.15	<del>Alcohol</del>	<del>beer or wine table service</del>	<del>\$150</del>
280.16		<del>alcohol service from bar</del>	<del>\$250</del>
280.17	Lodging	less than 25 rooms	\$250
280.18		25 to less than 100 rooms	\$300
280.19		100 rooms or more	\$450
280.20		less than five cabins	\$250
280.21		five to less than ten cabins	\$350
280.22		ten cabins or more	\$400

280.23 ~~(g)~~ (c) Special event food stands are not required to submit construction or  
280.24 remodeling plans for review.

280.25 ~~(h)~~ Youth camps shall pay an annual single fee for food and lodging as follows:

280.26 ~~(1) camps with up to 99 campers, \$325;~~

280.27 ~~(2) camps with 100 to 199 campers, \$550; and~~

280.28 ~~(3) camps with 200 or more campers, \$750.~~

280.29 ~~(i) A youth camp which pays fees under paragraph (d) is not required to pay fees~~  
280.30 ~~under paragraph (h).~~

280.31 Subd. 3a. 3b. **Statewide hospitality fee.** Every person, firm, or corporation that  
280.32 operates a licensed boarding establishment, food and beverage service establishment,  
280.33 seasonal temporary or permanent food stand, special event food stand, mobile food unit,  
280.34 food cart, resort, hotel, motel, or lodging establishment in Minnesota must submit to the  
280.35 commissioner a \$35 annual statewide hospitality fee for each licensed activity. The fee  
280.36 for establishments licensed by the Department of Health is required at the same time the  
280.37 licensure fee is due. For establishments licensed by local governments, the fee is due by  
280.38 July 1 of each year.

280.39 Subd. 4. **Posting requirements.** Every food and beverage service establishment,  
280.40 for-profit youth camp, hotel, motel, lodging establishment, public pool, or resort must



281.1 have the original license posted in a conspicuous place at the establishment. ~~Mobile food~~  
 281.2 ~~units, food carts, and seasonal temporary food stands shall be issued decals with the~~  
 281.3 ~~initial license and each calendar year with license renewals. The current license year~~  
 281.4 ~~decal must be placed on the unit or stand in a location determined by the commissioner.~~  
 281.5 ~~Decals are not transferable.~~

281.6 Subd. 5. **Special revenue fund.** Fees collected under this section shall be deposited  
 281.7 in the state treasury and credited to the state government special revenue fund.

281.8 Sec. 51. Minnesota Statutes 2014, section 169.686, subdivision 3, is amended to read:

281.9 Subd. 3. **Appropriation; special account.** The fines collected for a violation of  
 281.10 subdivision 1 must be deposited in the state treasury and credited to a special account to  
 281.11 be known as the emergency medical services relief account. Ninety percent of the money  
 281.12 in the account shall be ~~distributed~~ appropriated to the commissioner of health for the eight  
 281.13 regional emergency medical services systems designated by the Emergency Medical  
 281.14 Services Regulatory Board under section 144E.50, for personnel education and training,  
 281.15 equipment and vehicle purchases, and operational expenses of emergency life support  
 281.16 transportation services program grants as specified in section 144E.50, subdivision 3,  
 281.17 for the purposes specified in section 144E.50, subdivision 4. The board of directors of  
 281.18 each entity receiving a regional emergency medical services region program grant shall  
 281.19 establish criteria for funding. Ten percent of the money in the account shall be distributed  
 281.20 to the commissioner of public safety for the expenses of traffic safety educational  
 281.21 programs conducted by State Patrol troopers.

281.22 Sec. 52. **WORKING GROUP ON VIOLENCE AGAINST ASIAN WOMEN**  
 281.23 **AND CHILDREN.**

281.24 Subdivision 1. **Establishment.** The commissioner of health, in collaboration with  
 281.25 the commissioners of human services and public safety, and the Council on Asian-Pacific  
 281.26 Minnesotans, shall create a multidisciplinary working group to address violence against  
 281.27 Asian women and children by July 1, 2015.

281.28 Subd. 2. **The working group.** The commissioner of health, in collaboration with  
 281.29 the commissioners of human services and public safety, and the Council on Asian-Pacific  
 281.30 Minnesotans, shall appoint 15 members representing the following groups to participate in  
 281.31 the working group:

281.32 (1) advocates;

281.33 (2) survivors;

281.34 (3) service providers;

- 282.1 (4) community leaders;  
282.2 (5) city and county attorneys;  
282.3 (6) city officials;  
282.4 (7) law enforcement; and  
282.5 (8) health professionals.

282.6 At least eight of the members of the working group must be from the Asian-Pacific  
282.7 Islander community.

282.8 Subd. 3. **Duties.** (a) The working group must study the nature, scope, and prevalence  
282.9 of violence against Asian women and children in Minnesota, including domestic violence,  
282.10 trafficking, international abusive marriage, stalking, sexual assault, and other violence.

282.11 (b) The working group may:

- 282.12 (1) evaluate the adequacy and effectiveness of existing support programs;  
282.13 (2) conduct a needs assessment of culturally and linguistically appropriate programs  
282.14 and interventions;  
282.15 (3) identify barriers in delivering services to Asian women and children;  
282.16 (4) identify promising prevention and intervention strategies in addressing violence  
282.17 against Asian women and children; and  
282.18 (5) propose mechanisms to collect and monitor data on violence against Asian  
282.19 women and children.

282.20 Subd. 4. **Chair.** The commissioner of health shall designate one member to serve as  
282.21 chair of the working group.

282.22 Subd. 5. **First meeting.** The chair shall convene the first meeting by September  
282.23 10, 2015.

282.24 Subd. 6. **Compensation; expense reimbursement.** Members of the working group  
282.25 shall be compensated and reimbursed for expenses under Minnesota Statutes, section  
282.26 15.059, subdivision 3.

282.27 Subd. 7. **Report.** By January 1, 2017, the working group must submit its  
282.28 recommendations and any draft legislation necessary to implement those recommendations  
282.29 to the commissioners of health, human services, and public safety, and the Council on  
282.30 Asian-Pacific Minnesotans. The Council on Asian-Pacific Minnesotans shall submit a  
282.31 report of findings and recommendations to the chair and ranking minority members of the  
282.32 committees in the house of representatives and senate having jurisdiction over health and  
282.33 human services and public safety by February 15, 2017.

282.34 Subd. 8. **Sunset.** The working group on violence against Asian women and children  
282.35 sunsets the day after the Council on Asian-Pacific Minnesotans submits the report under  
282.36 subdivision 7.

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

283.2 Sec. 53. **REVISOR'S INSTRUCTION.**

283.3 The revisor of statutes shall recodify Minnesota Statutes, section 144E.50, as a  
 283.4 section in Minnesota Statutes, chapter 144, and make conforming changes consistent  
 283.5 with the renumbering.

283.6 Sec. 54. **REPEALER.**

283.7 Minnesota Statutes 2014, section 144E.52, is repealed.

## 283.8 **ARTICLE 8**

### 283.9 **HEALTH CARE DELIVERY**

283.10 Section 1. **[62A.67] SHORT TITLE.**

283.11 Sections 62A.67 to 62A.672 may be cited as the "Minnesota Telemedicine Act."

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

283.13 Sec. 2. **[62A.671] DEFINITIONS.**

283.14 Subdivision 1. **Applicability.** For purposes of sections 62A.67 to 62A.672, the  
 283.15 terms defined in this section have the meanings given.

283.16 Subd. 2. **Distant site.** "Distant site" means a site at which a licensed health care  
 283.17 provider is located while providing health care services or consultations by means of  
 283.18 telemedicine.

283.19 Subd. 3. **Health care provider.** "Health care provider" has the meaning provided  
 283.20 in section 62A.63, subdivision 2.

283.21 Subd. 4. **Health carrier.** "Health carrier" has the meaning provided in section  
 283.22 62A.011, subdivision 2.

283.23 Subd. 5. **Health plan.** "Health plan" means a health plan as defined in section  
 283.24 62A.011, subdivision 3, and includes dental plans as defined in section 62Q.76, subdivision  
 283.25 3, but does not include dental plans that provide indemnity-based benefits, regardless of  
 283.26 expenses incurred and are designed to pay benefits directly to the policyholder.

283.27 Subd. 6. **Licensed health care provider.** "Licensed health care provider" means a  
 283.28 health care provider who is:

283.29 (1) licensed under chapter 147, 147A, 148, 148B, 148E, 148F, 150A, or 153; a  
 283.30 mental health professional as defined under section 245.462, subdivision 18, or 245.4871,  
 283.31 subdivision 27; or vendor of medical care defined in section 256B.02, subdivision 7; and

284.1 (2) authorized within their respective scope of practice to provide the particular  
284.2 service with no supervision or under general supervision.

284.3 Subd. 7. **Originating site.** "Originating site" means a site including, but not limited  
284.4 to, a health care facility at which a patient is located at the time health care services are  
284.5 provided to the patient by means of telemedicine.

284.6 Subd. 8. **Store-and-forward technology.** "Store-and-forward technology" means  
284.7 the transmission of a patient's medical information from an originating site to a health care  
284.8 provider at a distant site without the patient being present, or the delivery of telemedicine  
284.9 that does not occur in real time via synchronous transmissions.

284.10 Subd. 9. **Telemedicine.** "Telemedicine" means the delivery of health care services  
284.11 or consultations while the patient is at an originating site and the licensed health care  
284.12 provider is at a distant site. A communication between licensed health care providers  
284.13 that consists solely of a telephone conversation, e-mail, or facsimile transmissions does  
284.14 not constitute telemedicine consultations or services. Telemedicine may be provided by  
284.15 means of real-time two-way, interactive audio and visual communications, including the  
284.16 application of secure video conferencing or store-and-forward technology to provide or  
284.17 support health care delivery, which facilitate the assessment, diagnosis, consultation,  
284.18 treatment, education, and care management of a patient's health care.

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

284.20 Sec. 3. **[62A.672] COVERAGE OF TELEMEDICINE SERVICES.**

284.21 Subdivision 1. **Coverage of telemedicine.** (a) A health plan sold, issued, or renewed  
284.22 by a health carrier for which coverage of benefits begins on or after January 1, 2017, shall  
284.23 include coverage for telemedicine benefits in the same manner as any other benefits covered  
284.24 under the policy, plan, or contract, and shall comply with the regulations of this section.

284.25 (b) Nothing in this section shall be construed to:

284.26 (1) require a health carrier to provide coverage for services that are not medically  
284.27 necessary;

284.28 (2) prohibit a health carrier from establishing criteria that a health care provider  
284.29 must meet to demonstrate the safety or efficacy of delivering a particular service via  
284.30 telemedicine for which the health carrier does not already reimburse other health  
284.31 care providers for delivering via telemedicine, so long as the criteria are not unduly  
284.32 burdensome or unreasonable for the particular service; or

284.33 (3) prevent a health carrier from requiring a health care provider to agree to certain  
284.34 documentation or billing practices designed to protect the health carrier or patients from

285.1 fraudulent claims so long as the practices are not unduly burdensome or unreasonable  
285.2 for the particular service.

285.3 Subd. 2. **Parity between telemedicine and in-person services.** A health carrier  
285.4 shall not exclude a service for coverage solely because the service is provided via  
285.5 telemedicine and is not provided through in-person consultation or contact between a  
285.6 licensed health care provider and a patient.

285.7 Subd. 3. **Reimbursement for telemedicine services.** (a) A health carrier shall  
285.8 reimburse the distant site licensed health care provider for covered services delivered via  
285.9 telemedicine on the same basis and at the same rate as the health carrier would apply to  
285.10 those services if the services had been delivered in person by the distant site licensed  
285.11 health care provider.

285.12 (b) It is not a violation of this subdivision for a health carrier to include a  
285.13 deductible, co-payment, or coinsurance requirement for a health care service provided via  
285.14 telemedicine, provided that the deductible, co-payment, or coinsurance is not in addition  
285.15 to, and does not exceed, the deductible, co-payment, or coinsurance applicable if the same  
285.16 services were provided through in-person contact.

285.17 Subd. 4. **Originating site facility fee payment.** If a health care provider provides  
285.18 the facility used as the originating site for the delivery of telemedicine to a health carrier's  
285.19 enrollee, the health carrier shall make a facility fee payment to the originating site health  
285.20 care provider. The facility fee payment to the originating site health care provider shall be  
285.21 in addition to the reimbursement to the distant site licensed health care provider specified  
285.22 in subdivision 3. The facility fee payment shall not be subject to any patient coinsurance,  
285.23 deductible, or co-payment obligation.

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

285.25 Sec. 4. Minnesota Statutes 2014, section 62J.497, subdivision 1, is amended to read:

285.26 Subdivision 1. **Definitions.** For the purposes of this section, the following terms  
285.27 have the meanings given.

285.28 (a) "Backward compatible" means that the newer version of a data transmission  
285.29 standard would retain, at a minimum, the full functionality of the versions previously  
285.30 adopted, and would permit the successful completion of the applicable transactions with  
285.31 entities that continue to use the older versions.

285.32 (b) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision  
285.33 30. Dispensing does not include the direct administering of a controlled substance to a  
285.34 patient by a licensed health care professional.

286.1 (c) "Dispenser" means a person authorized by law to dispense a controlled substance,  
286.2 pursuant to a valid prescription.

286.3 (d) "Electronic media" has the meaning given under Code of Federal Regulations,  
286.4 title 45, part 160.103.

286.5 (e) "E-prescribing" means the transmission using electronic media of prescription  
286.6 or prescription-related information between a prescriber, dispenser, pharmacy benefit  
286.7 manager, or group purchaser, either directly or through an intermediary, including  
286.8 an e-prescribing network. E-prescribing includes, but is not limited to, two-way  
286.9 transmissions between the point of care and the dispenser and two-way transmissions  
286.10 related to eligibility, formulary, and medication history information.

286.11 (f) "Electronic prescription drug program" means a program that provides for  
286.12 e-prescribing.

286.13 (g) "Group purchaser" has the meaning given in section 62J.03, subdivision 6, but  
286.14 does not include workers' compensation plans or the medical component of automobile  
286.15 insurance coverage.

286.16 (h) "HL7 messages" means a standard approved by the standards development  
286.17 organization known as Health Level Seven.

286.18 (i) "National Provider Identifier" or "NPI" means the identifier described under Code  
286.19 of Federal Regulations, title 45, part 162.406.

286.20 (j) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

286.21 (k) "NCPDP Formulary and Benefits Standard" means the National Council for  
286.22 Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide,  
286.23 Version 1, Release 0, October 2005.

286.24 (l) "NCPDP SCRIPT Standard" means the National Council for Prescription Drug  
286.25 Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide  
286.26 Version 8, Release 1 (Version 8.1), October 2005, or the most recent standard adopted by  
286.27 the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part  
286.28 D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations  
286.29 adopted under it. The standards shall be implemented according to the Centers for  
286.30 Medicare and Medicaid Services schedule for compliance. Subsequently released  
286.31 versions of the NCPDP SCRIPT Standard may be used, provided that the new version  
286.32 of the standard is backward compatible to the current version adopted by the Centers for  
286.33 Medicare and Medicaid Services.

286.34 (m) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

286.35 (n) "Prescriber" means a licensed health care practitioner, other than a veterinarian,  
286.36 as defined in section 151.01, subdivision 23.

287.1 (o) "Prescription-related information" means information regarding eligibility for  
287.2 drug benefits, medication history, or related health or drug information.

287.3 (p) "Provider" or "health care provider" has the meaning given in section 62J.03,  
287.4 subdivision 8.

287.5 (q) "Utilization review organization" has the meaning given in section 62M.02,  
287.6 subdivision 21.

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

287.8 Sec. 5. Minnesota Statutes 2014, section 62J.497, subdivision 3, is amended to read:

287.9 Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers  
287.10 must use the NCPDP SCRIPT Standard for the communication of a prescription or  
287.11 prescription-related information. The NCPDP SCRIPT Standard shall be used to conduct  
287.12 the following transactions:

- 287.13 (1) get message transaction;
- 287.14 (2) status response transaction;
- 287.15 (3) error response transaction;
- 287.16 (4) new prescription transaction;
- 287.17 (5) prescription change request transaction;
- 287.18 (6) prescription change response transaction;
- 287.19 (7) refill prescription request transaction;
- 287.20 (8) refill prescription response transaction;
- 287.21 (9) verification transaction;
- 287.22 (10) password change transaction;
- 287.23 (11) cancel prescription request transaction; and
- 287.24 (12) cancel prescription response transaction.

287.25 (b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP  
287.26 SCRIPT Standard for communicating and transmitting medication history information.

287.27 (c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP  
287.28 Formulary and Benefits Standard for communicating and transmitting formulary and  
287.29 benefit information.

287.30 (d) Group purchasers, prescribers, pharmacies, and utilization review organizations  
287.31 must collaborate to develop processes to ensure notification to prescribers upon denial of a  
287.32 claim for a prescribed drug that is not covered or is not included on the group purchaser's  
287.33 formulary. The process must provide a list of covered drugs from the same class or  
287.34 classes as the drug originally prescribed. If the NCPDP SCRIPT Standard or the NCPDP  
287.35 Formulary and Benefits Standard do not allow for the inclusion of this information, group

288.1 purchasers, prescribers, pharmacies, and utilization review organizations must develop  
 288.2 telephone, facsimile, or other secure electronic processes to communicate this information  
 288.3 to the prescriber. The development of this process shall be done under the auspices of the  
 288.4 administrative uniformity committee and take into consideration capabilities available in  
 288.5 electronic medical records.

288.6 ~~(d)~~ (e) Providers, group purchasers, prescribers, and dispensers must use the national  
 288.7 provider identifier to identify a health care provider in e-prescribing or prescription-related  
 288.8 transactions when a health care provider's identifier is required.

288.9 ~~(e)~~ (f) Providers, group purchasers, prescribers, and dispensers must communicate  
 288.10 eligibility information and conduct health care eligibility benefit inquiry and response  
 288.11 transactions according to the requirements of section 62J.536.

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

288.13 Sec. 6. Minnesota Statutes 2014, section 62J.497, subdivision 4, is amended to read:

288.14 Subd. 4. **Development and use of uniform formulary exception form.** (a) The  
 288.15 commissioner of health, in consultation with the Minnesota Administrative Uniformity  
 288.16 Committee, shall develop by July 1, 2009, a uniform formulary exception form that allows  
 288.17 health care providers to request exceptions from group purchaser formularies using a  
 288.18 uniform form. Upon development of the form, all health care providers must submit  
 288.19 requests for formulary exceptions using the uniform form, and all group purchasers must  
 288.20 accept this form from health care providers.

288.21 (b) ~~No later than January 1, 2011,~~ The uniform formulary exception form must be  
 288.22 accessible and submitted by health care providers, and accepted and processed by group  
 288.23 purchasers, through secure electronic transmissions. No later than September 1, 2015,  
 288.24 the uniform formulary exception form shall be updated to reflect evolving pharmacy and  
 288.25 prior authorization requirements.

288.26 (c) Health care providers, group purchasers, prescribers, dispensers, and utilization  
 288.27 review organizations using paper forms for prescription drug prior authorization or for  
 288.28 medical exception requests as defined in section 62Q.85, subdivision 5, must only use the  
 288.29 uniform formulary exception form.

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

288.31 Sec. 7. Minnesota Statutes 2014, section 62J.497, subdivision 5, is amended to read:

288.32 Subd. 5. **Electronic drug prior authorization standardization and transmission.**  
 288.33 (a) The commissioner of health, in consultation with the Minnesota e-Health Advisory



289.1 Committee and the Minnesota Administrative Uniformity Committee, shall, by February  
289.2 15, 2010, identify an outline on how best to standardize drug prior authorization request  
289.3 transactions between providers and group purchasers with the goal of maximizing  
289.4 administrative simplification and efficiency in preparation for electronic transmissions.

289.5 (b) By January 1, 2014, the Minnesota Administrative Uniformity Committee shall  
289.6 develop the standard companion guide by which providers and group purchasers will  
289.7 exchange standard drug authorization requests using electronic data interchange standards,  
289.8 if available, with the goal of alignment with standards that are or will potentially be used  
289.9 nationally.

289.10 (c) Testing of the electronic drug prior authorization transmission must begin no  
289.11 later than October 1, 2015.

289.12 (d) No later than January 1, 2016, drug prior authorization requests must be  
289.13 accessible and submitted by health care providers, and accepted by group purchasers,  
289.14 electronically through secure electronic transmissions. Facsimile shall not be considered  
289.15 electronic transmission.

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

289.17 Sec. 8. Minnesota Statutes 2014, section 62M.01, subdivision 2, is amended to read:

289.18 Subd. 2. **Jurisdiction.** (a) Sections 62M.01 to ~~62M.16~~ 62M.17 apply to any  
289.19 insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident  
289.20 and sickness insurance as defined in section 62A.01; a health service plan licensed  
289.21 under chapter 62C; a health maintenance organization licensed under chapter 62D; the  
289.22 Minnesota Comprehensive Health Association created under chapter 62E; a community  
289.23 integrated service network licensed under chapter 62N; an accountable provider network  
289.24 operating under chapter 62T; a fraternal benefit society operating under chapter 64B;  
289.25 a joint self-insurance employee health plan operating under chapter 62H; a multiple  
289.26 employer welfare arrangement, as defined in section 3 of the Employee Retirement Income  
289.27 Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended;  
289.28 a third-party administrator licensed under section 60A.23, subdivision 8, that provides  
289.29 utilization review services for the administration of benefits under a health benefit plan  
289.30 as defined in section 62M.02; or any entity performing utilization review on behalf of a  
289.31 business entity in this state pursuant to a health benefit plan covering a Minnesota resident.

289.32 (b) Sections 62M.01 to 62M.17 do not apply to the medical assistance fee-for-service  
289.33 program under chapter 256B, unless otherwise required in law or regulation.

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

290.1 Sec. 9. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision  
290.2 to read:

290.3 Subd. 10a. **Drug.** "Drug" has the meaning given in section 151.01, subdivision 5.

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

290.5 Sec. 10. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision  
290.6 to read:

290.7 Subd. 11a. **Formulary.** "Formulary" has the meaning given in section 62Q.85,  
290.8 subdivision 1.

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

290.10 Sec. 11. Minnesota Statutes 2014, section 62M.02, subdivision 12, is amended to read:

290.11 Subd. 12. **Health benefit plan.** "Health benefit plan" means a policy, contract, or  
290.12 certificate issued by a health plan company for the coverage of medical, dental, prescription  
290.13 drug, or hospital benefits. A health benefit plan does not include coverage that is:

290.14 (1) limited to disability or income protection coverage;

290.15 (2) automobile medical payment coverage;

290.16 (3) supplemental to liability insurance;

290.17 (4) designed solely to provide payments on a per diem, fixed indemnity, or  
290.18 nonexpense incurred basis;

290.19 (5) credit accident and health insurance issued under chapter 62B;

290.20 (6) blanket accident and sickness insurance as defined in section 62A.11;

290.21 (7) accident only coverage issued by a licensed and tested insurance agent; or

290.22 (8) workers' compensation.

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

290.24 Sec. 12. Minnesota Statutes 2014, section 62M.02, subdivision 14, is amended to read:

290.25 Subd. 14. **Outpatient services.** "Outpatient services" means procedures or services  
290.26 performed on a basis other than as an inpatient, and includes obstetrical, psychiatric,  
290.27 chemical dependency, dental, prescription drug, and chiropractic services.

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

290.29 Sec. 13. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision  
290.30 to read:

291.1 Subd. 14b. **Prescription.** "Prescription" has the meaning given in section 151.01,  
291.2 subdivision 16a.

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

291.4 Sec. 14. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision  
291.5 to read:

291.6 Subd. 14c. **Prescription drug order.** "Prescription drug order" has the meaning  
291.7 given in section 151.01, subdivision 16.

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

291.9 Sec. 15. Minnesota Statutes 2014, section 62M.02, subdivision 15, is amended to read:

291.10 Subd. 15. **Prior authorization.** "Prior authorization" means utilization review  
291.11 conducted prior to the delivery of a service, including an outpatient service. Prior  
291.12 authorization includes, but is not limited to, preadmission review, pretreatment review,  
291.13 quantity limits, step therapy, utilization, and case management. Prior authorization also  
291.14 includes any utilization review organization's requirement that an enrollee or provider  
291.15 notify the utilization review organization prior to providing a service, including an  
291.16 outpatient service. Reviews performed for emergency medical assistance benefits, medical  
291.17 assistance waived services, or the Minnesota restricted recipient program are not prior  
291.18 authorization.

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

291.20 Sec. 16. Minnesota Statutes 2014, section 62M.02, subdivision 17, is amended to read:

291.21 Subd. 17. **Provider.** "Provider" means a licensed health care facility, physician,  
291.22 pharmacist, or other health care professional that delivers health care services to an enrollee.

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

291.24 Sec. 17. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision  
291.25 to read:

291.26 Subd. 18a. **Quantity limit.** "Quantity limit" means a limit on the number of doses  
291.27 of a prescription drug that are covered during a specific time period.

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

292.1 Sec. 18. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision  
292.2 to read:

292.3 Subd. 19a. **Step therapy.** "Step therapy" means clinical practice or other  
292.4 evidence-based protocols or requirements that specify the sequence in which different  
292.5 prescription drugs for a given medical condition are to be used by an enrollee before a  
292.6 drug prescribed by a provider is covered. Step therapy does not include a requirement  
292.7 for an enrollee to use a generic or biosimilar product considered by the Food and Drug  
292.8 Administration to be therapeutically equivalent and interchangeable to a branded product,  
292.9 provided the generic or biosimilar product has not previously been tried by the patient.

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

292.11 Sec. 19. Minnesota Statutes 2014, section 62M.05, subdivision 3a, is amended to read:

292.12 Subd. 3a. **Standard review determination.** (a) Notwithstanding subdivision 3b, an  
292.13 initial determination on all requests for utilization review, except a determination related  
292.14 to prescription drugs, must be communicated to the provider and enrollee in accordance  
292.15 with this subdivision within ten business days of the request, provided that all information  
292.16 reasonably necessary to make a determination on the request has been made available to  
292.17 the utilization review organization.

292.18 (b) An initial determination for utilization review on all prescription drug requests  
292.19 must be communicated to the provider and enrollee in accordance with this subdivision  
292.20 within five business days of the request, provided that all information reasonably necessary  
292.21 to make a determination on the request has been made available to the utilization review  
292.22 organization.

292.23 (c) When an initial determination is made to certify, notification must be provided  
292.24 promptly by telephone to the provider. The utilization review organization shall send  
292.25 written notification to the provider or shall maintain an audit trail of the determination  
292.26 and telephone notification. For purposes of this subdivision, "audit trail" includes  
292.27 documentation of the telephone notification, including the date; the name of the person  
292.28 spoken to; the enrollee; the service, procedure, or admission certified; and the date of  
292.29 the service, procedure, or admission. If the utilization review organization indicates  
292.30 certification by use of a number, the number must be called the "certification number."  
292.31 For purposes of this subdivision, notification may also be made by facsimile to a verified  
292.32 number or by electronic mail to a secure electronic mailbox. These electronic forms of  
292.33 notification satisfy the "audit trail" requirement of this paragraph.

292.34 (e) (d) When an initial determination is made not to certify, notification must be  
292.35 provided by telephone, by facsimile to a verified number, or by electronic mail to a secure

293.1 electronic mailbox within one working day after making the determination to the attending  
293.2 health care professional and hospital as applicable. Written notification must also be sent  
293.3 to the hospital as applicable and attending health care professional if notification occurred  
293.4 by telephone. For purposes of this subdivision, notification may be made by facsimile to a  
293.5 verified number or by electronic mail to a secure electronic mailbox. Written notification  
293.6 must be sent to the enrollee and may be sent by United States mail, facsimile to a verified  
293.7 number, or by electronic mail to a secure mailbox. The written notification must include  
293.8 the principal reason or reasons for the determination and the process for initiating an appeal  
293.9 of the determination. Upon request, the utilization review organization shall provide the  
293.10 provider or enrollee with the criteria used to determine the necessity, appropriateness,  
293.11 and efficacy of the health care service and identify the database, professional treatment  
293.12 parameter, or other basis for the criteria. Reasons for a determination not to certify may  
293.13 include, among other things, the lack of adequate information to certify after a reasonable  
293.14 attempt has been made to contact the provider or enrollee.

293.15 ~~(d)~~ (e) When an initial determination is made not to certify, the written notification  
293.16 must inform the enrollee and the attending health care professional of the right to submit  
293.17 an appeal to the internal appeal process described in section 62M.06 and the procedure  
293.18 for initiating the internal appeal. The written notice shall be provided in a culturally and  
293.19 linguistically appropriate manner consistent with the provisions of the Affordable Care  
293.20 Act as defined under section 62A.011, subdivision 1a.

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

293.22 Sec. 20. Minnesota Statutes 2014, section 62M.05, subdivision 3b, is amended to read:

293.23 Subd. 3b. **Expedited review determination.** (a) An expedited initial determination  
293.24 must be utilized if the attending health care professional believes that an expedited  
293.25 determination is warranted.

293.26 (b) Notification of an expedited initial determination to either certify or not to  
293.27 certify, except a determination related to prescription drugs, must be provided to the  
293.28 hospital, the attending health care professional, and the enrollee as expeditiously as the  
293.29 enrollee's medical condition requires, but no later than 72 hours from the initial request.  
293.30 When an expedited initial determination is made not to certify, the utilization review  
293.31 organization must also notify the enrollee and the attending health care professional of the  
293.32 right to submit an appeal to the expedited internal appeal as described in section 62M.06  
293.33 and the procedure for initiating an internal expedited appeal.

293.34 (c) Notification of an expedited initial determination to either certify or not to  
293.35 certify on all prescription drug requests must be provided to the hospital, the attending

294.1 health care professional, and the enrollee as expeditiously as the enrollee's medical  
294.2 condition requires, but no later than 36 hours from the initial request, provided that all the  
294.3 information reasonably necessary to make a determination has been made available to the  
294.4 utilization review organization. For state public health care programs administered under  
294.5 section 256B.69 and chapter 256L, notification must be provided to the hospital, attending  
294.6 health care provider, or the enrollee as expeditiously as the enrollee's condition requires,  
294.7 but no later than 36 hours from the initial request, provided that all the information  
294.8 reasonably necessary to make a determination has been made available to the utilization  
294.9 review organization. When an expedited initial determination is made not to certify, the  
294.10 utilization review organization must also notify the enrollee and the attending health care  
294.11 professional of the right to submit an appeal to the expedited internal appeal as described  
294.12 in section 62M.06 and the procedure for initiating an internal expedited appeal.

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

294.14 Sec. 21. Minnesota Statutes 2014, section 62M.05, subdivision 4, is amended to read:

294.15 Subd. 4. **Failure to provide necessary information.** A utilization review  
294.16 organization must have written procedures to address the failure of a provider or  
294.17 enrollee to provide the necessary information for review, and to address processes by  
294.18 which the utilization review organization must track and manage review requests and  
294.19 documentation submitted by providers or enrollees. If the enrollee or provider will not  
294.20 release the necessary information to the utilization review organization, the utilization  
294.21 review organization may deny certification in accordance with its own policy or the policy  
294.22 described in the health benefit plan. If a utilization review organization fails to meet the  
294.23 timelines in subdivision 3a or 3b for a completed prescription drug review request, or fails  
294.24 to notify the provider that information needed to conduct the prescription drug review is  
294.25 incomplete, or if a utilization review organization fails to properly maintain submitted  
294.26 records for which the provider or enrollee has documentation of submission, the service  
294.27 shall be deemed approved.

294.28 **EFFECTIVE DATE.** This section is effective January 1, 2017.

294.29 Sec. 22. Minnesota Statutes 2014, section 62M.06, subdivision 2, is amended to read:

294.30 Subd. 2. **Expedited appeal.** (a) When an initial determination not to certify a  
294.31 health care service is made prior to or during an ongoing service requiring review  
294.32 and the attending health care professional believes that the determination warrants an  
294.33 expedited appeal, the utilization review organization must ensure that the enrollee and the

295.1 attending health care professional have an opportunity to appeal the determination over  
295.2 the telephone on an expedited basis. In such an appeal, the utilization review organization  
295.3 must ensure reasonable access to its consulting physician or health care provider.

295.4 (b) The utilization review organization shall notify the enrollee and attending  
295.5 health care professional by telephone of its determination, except for determinations  
295.6 related to prescription drugs, on the expedited appeal as expeditiously as the enrollee's  
295.7 medical condition requires, but no later than 72 hours after receiving the expedited appeal.  
295.8 The utilization review organization shall notify the enrollee and attending health care  
295.9 professional by telephone of its determination on the expedited appeal of a prescription  
295.10 drug request as expeditiously as the enrollee's medical condition requires, but no later than  
295.11 36 hours after receiving the expedited appeal.

295.12 (c) If the determination not to certify is not reversed through the expedited appeal,  
295.13 the utilization review organization must include in its notification the right to submit the  
295.14 appeal to the external appeal process described in section 62Q.73 and the procedure for  
295.15 initiating the process. This information must be provided in writing to the enrollee and  
295.16 the attending health care professional as soon as practical.

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

295.18 Sec. 23. Minnesota Statutes 2014, section 62M.06, subdivision 3, is amended to read:

295.19 Subd. 3. **Standard appeal.** The utilization review organization must establish  
295.20 procedures for appeals to be made either in writing or by telephone.

295.21 (a) A utilization review organization shall notify in writing the enrollee, attending  
295.22 health care professional, and claims administrator of its determination on the appeal,  
295.23 except for determinations related to prescription drugs, within 30 days upon receipt of the  
295.24 notice of appeal. If the utilization review organization cannot make a determination within  
295.25 30 days due to circumstances outside the control of the utilization review organization, the  
295.26 utilization review organization may take up to 14 additional days to notify the enrollee,  
295.27 attending health care professional, and claims administrator of its determination. If the  
295.28 utilization review organization takes any additional days beyond the initial 30-day period  
295.29 to make its determination, it must inform the enrollee, attending health care professional,  
295.30 and claims administrator, in advance, of the extension and the reasons for the extension.

295.31 (b) A utilization review organization shall notify in writing the enrollee, attending  
295.32 health care professional, and claims administrator of its determination on the appeal on a  
295.33 prescription drug within 15 days upon receipt of the notice of appeal. If the utilization  
295.34 review organization cannot make a determination on a prescription drug within 15 days  
295.35 due to circumstances outside the control of the utilization review organization, the

296.1 utilization review organization may take up to ten additional days to notify the enrollee,  
296.2 attending health care professional, and claims administration of its determination. If the  
296.3 utilization review organization takes any additional days beyond the initial 15-day period  
296.4 to make its determination, it must inform the enrollee, attending health care professional,  
296.5 and claims administrator, in advance, of the extension and the reasons for the extension.

296.6 (c) The documentation required by the utilization review organization may include  
296.7 copies of part or all of the medical record and a written statement from the attending  
296.8 health care professional.

296.9 (e) (d) Prior to upholding the initial determination not to certify for clinical reasons,  
296.10 the utilization review organization shall conduct a review of the documentation by a  
296.11 physician who did not make the initial determination not to certify.

296.12 (d) (e) The process established by a utilization review organization may include  
296.13 defining a period within which an appeal must be filed to be considered. The time period  
296.14 must be communicated to the enrollee and attending health care professional when the  
296.15 initial determination is made.

296.16 (e) (f) An attending health care professional or enrollee who has been unsuccessful  
296.17 in an attempt to reverse a determination not to certify shall, consistent with section  
296.18 72A.285, be provided the following:

296.19 (1) a complete summary of the review findings;

296.20 (2) qualifications of the reviewers, including any license, certification, or specialty  
296.21 designation; and

296.22 (3) the relationship between the enrollee's diagnosis and the review criteria used as  
296.23 the basis for the decision, including the specific rationale for the reviewer's decision.

296.24 (f) (g) In cases of appeal to reverse a determination not to certify for clinical reasons,  
296.25 the utilization review organization must ensure that a physician of the utilization review  
296.26 organization's choice in the same or a similar specialty as typically manages the medical  
296.27 condition, procedure, or treatment under discussion is reasonably available to review  
296.28 the case.

296.29 (g) (h) If the initial determination is not reversed on appeal, the utilization review  
296.30 organization must include in its notification the right to submit the appeal to the external  
296.31 review process described in section 62Q.73 and the procedure for initiating the external  
296.32 process.

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



297.1 Sec. 24. Minnesota Statutes 2014, section 62M.07, is amended to read:

297.2 **62M.07 PRIOR AUTHORIZATION OF SERVICES.**

297.3 (a) Utilization review organizations conducting prior authorization of services must  
297.4 have written standards that meet at a minimum the following requirements:

297.5 (1) written procedures and criteria used to determine whether care is appropriate,  
297.6 reasonable, or medically necessary;

297.7 (2) a system for providing prompt notification of its determinations to enrollees  
297.8 and providers and for notifying the provider, enrollee, or enrollee's designee of appeal  
297.9 procedures under clause (4);

297.10 (3) compliance with section 62M.05, subdivisions 3a and 3b, regarding time frames  
297.11 for approving and disapproving prior authorization requests;

297.12 (4) written procedures for appeals of denials of prior authorization which specify the  
297.13 responsibilities of the enrollee and provider, and which meet the requirements of sections  
297.14 62M.06 and 72A.285, regarding release of summary review findings; and

297.15 (5) procedures to ensure confidentiality of patient-specific information, consistent  
297.16 with applicable law.

297.17 (b) No utilization review organization, health plan company, or claims administrator  
297.18 may conduct or require prior authorization of emergency confinement or emergency  
297.19 treatment. The enrollee or the enrollee's authorized representative may be required to  
297.20 notify the health plan company, claims administrator, or utilization review organization  
297.21 as soon after the beginning of the emergency confinement or emergency treatment as  
297.22 reasonably possible.

297.23 (c) If prior authorization for a health care service is required, the utilization review  
297.24 organization, health plan company, or claim administrator must allow providers to submit  
297.25 requests for prior authorization of the health care services without unreasonable delay  
297.26 by telephone, facsimile, or voice mail or through an electronic mechanism 24 hours a  
297.27 day, seven days a week. This paragraph does not apply to dental service covered under  
297.28 MinnesotaCare, general assistance medical care, or medical assistance.

297.29 (d) Any prior authorization for a prescription drug must remain valid for the duration  
297.30 of an enrollee's benefit year, or for the benefits offered under section 256B.69 or chapter  
297.31 256L, any prior authorization for a prescription drug must remain valid for the duration of  
297.32 the enrollee's enrollment or one year, whichever is shorter, provided the drug continues to  
297.33 be prescribed for a patient with a condition that requires ongoing medication therapy, the  
297.34 drug has not otherwise been deemed unsafe by the Food and Drug Administration, has not  
297.35 been withdrawn by the manufacturer or the Food and Drug Administration, there is no  
297.36 evidence of the enrollee's abuse or misuse of the medication, or no independent source of

298.1 research, clinical guidelines, or evidence-based standards has issued drug-specific warnings  
298.2 or recommended changes in drug usage. This does not apply to individuals assigned to the  
298.3 restricted recipient program under Minnesota Rules, parts 9505.2160 to 9505.2245.

298.4 (e) No utilization review organization, health plan company, or claims administrator  
298.5 may impose step therapy requirements for enrollees currently taking a prescription drug,  
298.6 as substantiated from available claims data or provider documentation, in one of the  
298.7 following classes: (1) immunosuppressants; (2) antidepressants; (3) antipsychotics; (4)  
298.8 anticonvulsants; (5) antiretrovirals; or (6) antineoplastics. This provision does not apply to  
298.9 a patient who has initiated treatment for a condition with samples provided by a prescriber  
298.10 and provided that any step therapy requirements subsequently applied are consistent  
298.11 with evidence-based prescribing practices.

298.12 **EFFECTIVE DATE.** This section is effective January 1, 2017.

298.13 Sec. 25. Minnesota Statutes 2014, section 62M.09, subdivision 3, is amended to read:

298.14 Subd. 3. **Physician reviewer involvement.** (a) A physician must review all cases  
298.15 in which the utilization review organization has concluded that a determination not to  
298.16 certify for clinical reasons is appropriate.

298.17 (b) The physician conducting the review must be licensed in this state. ~~This~~  
298.18 ~~paragraph does not apply to reviews conducted in connection with policies issued by a~~  
298.19 ~~health plan company that is assessed less than three percent of the total amount assessed~~  
298.20 ~~by the Minnesota Comprehensive Health Association.~~

298.21 (c) The physician should be reasonably available by telephone to discuss the  
298.22 determination with the attending health care professional.

298.23 (d) This subdivision does not apply to outpatient mental health or substance abuse  
298.24 services governed by subdivision 3a.

298.25 **EFFECTIVE DATE.** This section is effective January 1, 2017.

298.26 Sec. 26. Minnesota Statutes 2014, section 62M.10, subdivision 7, is amended to read:

298.27 Subd. 7. **Availability of criteria.** Upon request, a utilization review organization  
298.28 shall provide to an enrollee, a provider, and the commissioner of commerce the written  
298.29 clinical criteria used to determine the medical necessity, appropriateness, and efficacy of a  
298.30 procedure or service and identify the database, professional treatment guideline, or other  
298.31 basis for the criteria. This requirement may be met by posting the written clinical criteria  
298.32 on the utilization review organization's public Web site or electronically distributing the  
298.33 information directly to the enrollee or provider.

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

299.2 Sec. 27. Minnesota Statutes 2014, section 62M.11, is amended to read:

299.3 **62M.11 COMPLAINTS TO COMMERCE OR HEALTH.**

299.4 Notwithstanding the provisions of sections 62M.01 to 62M.16, an enrollee or  
299.5 provider may file a complaint regarding compliance with the requirements of this chapter  
299.6 or regarding a determination not to certify directly to the commissioner responsible for  
299.7 regulating the utilization review organization.

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

299.9 Sec. 28. **[62M.17] REPORTING.**

299.10 On August 1, 2016, and each August 1 thereafter, utilization review organizations  
299.11 must report to the commissioner of health, on the forms and in the manner specified by the  
299.12 commissioner, the following information:

299.13 (1) for medical exception requests, the 25 most frequently requested drugs by  
299.14 exception type, including lack of available clinical alternative, ineffective formulary  
299.15 drug, and dosage limits; and

299.16 (2) for prescription drug prior authorization requests:

299.17 (i) the number and rate of initial approvals by commercial product and by prepaid  
299.18 medical assistance product types;

299.19 (ii) the number and rate of standard appeal approvals by commercial product and by  
299.20 prepaid medical assistance product types;

299.21 (iii) the number and rate of expedited appeal approvals by commercial product and  
299.22 by prepaid medical assistance product types;

299.23 (iv) for standard reviews, the range and average time from receipt of completed  
299.24 request to notification of decision;

299.25 (v) for expedited reviews, the range and average time from receipt of completed  
299.26 request to notification of decision;

299.27 (vi) for standard appeals, the range and average time from receipt of completed  
299.28 request to notification of decision; and

299.29 (vii) for expedited appeals, the range and average time from receipt of completed  
299.30 request to notification of decision.

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

300.1 Sec. 29. Minnesota Statutes 2014, section 62Q.02, is amended to read:

300.2 **62Q.02 APPLICABILITY OF CHAPTER.**

300.3 (a) This chapter applies only to health plans, as defined in section 62Q.01, and not to  
300.4 other types of insurance issued or renewed by health plan companies, unless otherwise  
300.5 specified.

300.6 (b) This chapter applies to a health plan company only with respect to health plans,  
300.7 as defined in section 62Q.01, issued or renewed by the health plan company, unless  
300.8 otherwise specified.

300.9 (c) If a health plan company issues or renews health plans in other states, this chapter  
300.10 applies only to health plans issued or renewed in this state for Minnesota residents, or to  
300.11 cover a resident of the state, unless otherwise specified.

300.12 (d) This chapter does not apply to public health care programs administered by the  
300.13 commissioner of human services under chapter 256B or 256L, unless otherwise required  
300.14 by law or regulation.

300.15 Sec. 30. **[62Q.83] FREEDOM OF CHOICE FOR PHARMACY SERVICES.**

300.16 Subdivision 1. **Enrollee choice.** No health plan company or pharmacy benefit  
300.17 manager that covers pharmaceutical services, including prescription drug coverage, shall  
300.18 limit or restrict an enrollee's ability to select a pharmacy or pharmacist of the enrollee's  
300.19 choice if the pharmacy or pharmacist is licensed under chapter 151, and the pharmacy  
300.20 or pharmacist has agreed to the terms of the health plan company's or pharmacy benefit  
300.21 manager's provider contract.

300.22 This subdivision does not apply to an enrollee in the Minnesota restricted recipient  
300.23 program pursuant to Minnesota Rules, part 9505.2238.

300.24 Subd. 2. **Provider network.** No health plan company or pharmacy benefit manager  
300.25 shall deny a pharmacy or pharmacist the right to participate in any of its pharmacy network  
300.26 contracts in this state or as a contracting provider in this state if the pharmacy or pharmacist  
300.27 has a valid license under chapter 151, and the pharmacy or pharmacist agrees to accept the  
300.28 terms and conditions offered by the health plan company or pharmacy benefit manager,  
300.29 and agrees to provide pharmacy services that meet state and federal laws and regulations.

300.30 Subd. 3. **Cost-sharing or other conditions.** No health plan company or pharmacy  
300.31 benefit manager shall impose a co-payment, fee, or other cost-sharing requirement  
300.32 for selecting a pharmacy or pharmacist of the enrollee's choosing or impose other  
300.33 conditions that limit or restrict an enrollee's ability to utilize a pharmacy of the enrollee's  
300.34 choosing, unless the health plan company or pharmacy benefit manager imposes the  
300.35 same cost-sharing requirements, fees, conditions, or limits upon an enrollee's selection of

301.1 any of the pharmacies within the health plan company's or pharmacy benefit manager's  
301.2 provider network contracts in this state.

301.3 Subd. 4. **Definitions.** (a) For purposes of this section, the terms in this subdivision  
301.4 have the meanings given.

301.5 (b) "Pharmacy" has the meaning given in section 151.01, subdivision 2, and includes  
301.6 mail order pharmacies and specialty pharmacies.

301.7 (c) "Pharmacy benefit manager" has the meaning given in section 151.71,  
301.8 subdivision 1.

301.9 **EFFECTIVE DATE.** This section is effective August 1, 2015, and applies to any  
301.10 health plan issued or renewed on or after that date.

301.11 Sec. 31. **[62Q.84] SERVICES PERFORMED BY A PHARMACIST.**

301.12 A health plan company or pharmacy benefit manager, as defined under section  
301.13 151.71, subdivision 1, shall provide payment for any health care service that is a covered  
301.14 benefit and is performed by a licensed pharmacist if: (1) the service performed is within  
301.15 the scope of practice of a licensed pharmacist under chapter 151; and (2) the health plan  
301.16 would cover the service if the service was performed by a physician licensed under chapter  
301.17 147; an advanced practice registered nurse licensed under section 148.211, subdivision  
301.18 1a; or a physician assistant licensed under chapter 147A.

301.19 **EFFECTIVE DATE.** This section is effective August 1, 2015, and applies to any  
301.20 health plan issued or renewed on or after that date.

301.21 Sec. 32. **[62Q.85] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND**  
301.22 **MANAGEMENT.**

301.23 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms  
301.24 have the meaning given them.

301.25 (b) "Drug" has the meaning given in section 151.01, subdivision 5.

301.26 (c) "Formulary" means a list of prescription drugs that have been developed by  
301.27 clinical and pharmacy experts and represents the health plan company's medically  
301.28 appropriate and cost-effective prescription drugs approved for use.

301.29 (d) "Health plan company" has the meaning given in section 62Q.01, subdivision 4,  
301.30 and includes an entity that performs pharmacy benefits management for the health plan  
301.31 company. For purposes of this definition, "pharmacy benefits management" means the  
301.32 administration or management of prescription drug benefits provided by the health plan  
301.33 company for the benefit of its enrollees and may include, but is not limited to, procurement

302.1 of prescription drugs, clinical formulary development and management services, claims  
302.2 processing, and rebate contracting and administration.

302.3 (e) "Prescription" has the meaning given in section 151.01, subdivision 16a.

302.4 Subd. 2. **Prescription drug benefit disclosure.** (a) A health plan company that  
302.5 provides prescription drug benefit coverage and uses a formulary must make its formulary  
302.6 and related benefit information available by electronic means and, upon request, in  
302.7 writing, at least 30 days prior to annual renewal dates.

302.8 (b) Formularies must be organized and disclosed consistent with the most recent  
302.9 version of the United States Pharmacopeia's (USP) Model Guidelines.

302.10 (c) For each item or category of items on the formulary, the specific enrollee benefit  
302.11 terms must be identified, including enrollee cost-sharing and expected out-of-pocket costs.

302.12 Subd. 3. **Formulary changes.** (a) Once a formulary has been established, a health  
302.13 plan company may, at any time during the enrollee's benefit year:

302.14 (1) expand its formulary by adding drugs to the formulary;

302.15 (2) reduce co-payments or coinsurance; or

302.16 (3) move a drug to a benefit category that reduces an enrollee's cost.

302.17 (b) A health plan company may remove a brand name drug from its formulary  
302.18 or place a brand name drug in a benefit category that increases an enrollee's cost only  
302.19 upon the addition to the formulary of an A-rated generic or multisource brand name  
302.20 equivalent at a lower cost to the enrollee, and upon at least a 60-day notice to prescribers,  
302.21 pharmacists, and affected enrollees.

302.22 (c) A health plan company is prohibited from removing drugs from its formulary or  
302.23 moving drugs to a benefit category that increases an enrollee's cost during the enrollee's  
302.24 benefit year. This paragraph does not apply to any changes associated with drugs that have  
302.25 been deemed unsafe by the Food and Drug Administration, that have been withdrawn  
302.26 by either the Food and Drug Administration or the product manufacturer, or where an  
302.27 independent source of research, clinical guidelines, or evidence-based standards has issued  
302.28 drug-specific warnings or recommended changes in drug usage.

302.29 (d) Managed care plans and county-based purchasing plans under section 256B.69  
302.30 and chapter 256L, are prohibited from removing drugs from its formulary or moving  
302.31 drugs to a benefit category that increases an enrollee's cost more than once annually unless  
302.32 an A-rated generic or multisource brand name equivalent is added to the formulary. This  
302.33 paragraph does not apply to any changes associated with drugs that have been deemed  
302.34 unsafe by the Food and Drug Administration, that have been withdrawn by either the Food  
302.35 and Drug Administration or the product manufacturer, or where an independent source

303.1 of research, clinical guidelines, or evidence-based standards has issued drug-specific  
303.2 warnings or recommended changes in drug usage.

303.3 Subd. 4. **Transition process.** (a) A health plan company must establish and  
303.4 maintain a transition process to prevent gaps in prescription drug coverage for both  
303.5 new and continuing enrollees with ongoing prescription drug needs who are affected  
303.6 by changes in formulary drug availability.

303.7 (b) The transition process must provide coverage for at least 60 days.

303.8 (c) Any enrollee cost-sharing applied must be based on the defined prescription drug  
303.9 benefit terms and must be consistent with any cost-sharing that the health plan company  
303.10 would charge for nonformulary drugs approved under a medication exceptions process.

303.11 (d) A health plan company must ensure that written notice is provided to each  
303.12 affected enrollee and prescriber within three business days after adjudication of the  
303.13 transition coverage.

303.14 Subd. 5. **Medication exceptions process.** (a) Each health plan company must  
303.15 establish and maintain a medication exceptions process that allows enrollees, providers,  
303.16 or an enrollee's authorized representative to request and obtain coverage approval for  
303.17 medications in the following situations:

303.18 (1) there is no acceptable clinical alternative listed on the formulary to treat the  
303.19 enrollee's disease or medical condition;

303.20 (2) the prescription listed on the formulary has been ineffective in the treatment of  
303.21 an enrollee's disease or medical condition or, based on clinical and scientific evidence and  
303.22 the relevant physical or mental characteristics of the enrollee, is likely to be ineffective or  
303.23 adversely affect the drug's effectiveness or the enrollee's medication compliance; or

303.24 (3) the number of doses that are available under a dose restriction has been  
303.25 ineffective in the treatment of the enrollee's disease or medical condition or, based on  
303.26 clinical and scientific evidence and the relevant physical or mental characteristics of  
303.27 the enrollee, is likely to be ineffective or adversely affect the drug's effectiveness or the  
303.28 enrollee's medication compliance.

303.29 (b) An approved medication exception request must remain valid for the duration of  
303.30 an enrollee's benefit term, or for benefits offered under section 265B.69 or chapter 256L,  
303.31 for the duration of the enrollee's enrollment, or one year, whichever is shorter, provided  
303.32 the medication continues to be prescribed for the same condition, and the medication has  
303.33 not otherwise been withdrawn by the manufacturer or the Food and Drug Administration.

303.34 (c) The medication exceptions process must comply with the requirements of  
303.35 chapter 62M.

304.1 Subd. 6. Prescription Drug Advisory Council. (a) A Prescription Drug Advisory  
304.2 Council has 11 members appointed by the commissioner of health with representation  
304.3 as follows:

304.4 (1) three patients;

304.5 (2) one physician licensed to practice medicine in Minnesota;

304.6 (3) two nonphysicians who are licensed in Minnesota to prescribe prescription drugs;

304.7 (4) one pharmacist licensed in Minnesota;

304.8 (5) one person representing a health plan company;

304.9 (6) one person representing a pharmacy benefit manager;

304.10 (7) one person representing pharmaceutical manufacturers; and

304.11 (8) one person who purchases health benefits for a group or an employer.

304.12 (b) Terms and removal of public members are as provided in section 15.0575, except  
304.13 that members will serve without compensation or expense reimbursement. A vacancy on  
304.14 the council may be filled by the appointing authority for the remainder of the unexpired  
304.15 term. Vacancies will be filled as provided in section 15.0597.

304.16 (c) The council shall select a chair from among its members. The chair may convene  
304.17 meetings as necessary to conduct the duties prescribed by this section.

304.18 (d) The duty of the council is to provide guidance to the commissioner of health  
304.19 in monitoring changes and trends in prescription drug coverage and formulary design.

304.20 The council must consult with the commissioner to assist the commissioner in preparing  
304.21 the report required under paragraph (g).

304.22 (e) The commissioner of health will provide administrative support and meeting  
304.23 space for the council to perform its duties.

304.24 (f) The Prescription Drug Advisory Council expires on January 30, 2021.

304.25 (g) Beginning January 15, 2017, and on at least a biennial basis thereafter, the  
304.26 commissioner, in consultation with the advisory group, shall submit a report to the chairs  
304.27 and lead minority members of the legislative committees with jurisdiction over health care  
304.28 coverage describing trends in prescription drug coverage, formulary design, medication  
304.29 exception requests, and benefit design. Health plan companies, pharmacy benefit managers,  
304.30 prescribers, and pharmacies must cooperate in providing information necessary for the  
304.31 advisory group to carry out its responsibilities, provided the commissioner, in consultation  
304.32 with the affected parties, does not determine the information to be of a proprietary nature.

304.33 **EFFECTIVE DATE.** Subdivisions 1 to 5 are effective January 1, 2017. Subdivision  
304.34 6 is effective August 1, 2015.

304.35 Sec. 33. Minnesota Statutes 2014, section 62U.02, subdivision 1, is amended to read:



305.1 Subdivision 1. **Development.** (a) The commissioner of health shall develop a  
305.2 standardized set of measures by which to assess the quality of health care services offered  
305.3 by health care providers, including health care providers certified as health care homes  
305.4 under section 256B.0751. Quality measures must be based on medical evidence and be  
305.5 developed through a process in which providers participate. The measures shall be used  
305.6 for the quality incentive payment system developed in subdivision 2 and must:

305.7 (1) include uniform definitions, measures, and forms for submission of data, to the  
305.8 greatest extent possible;

305.9 (2) seek to avoid increasing the administrative burden on health care providers;

305.10 (3) be initially based on existing quality indicators for physician and hospital  
305.11 services, which are measured and reported publicly by quality measurement organizations,  
305.12 including, but not limited to, Minnesota Community Measurement and specialty societies;

305.13 (4) place a priority on measures of health care outcomes, rather than process  
305.14 measures, wherever possible; and

305.15 (5) incorporate measures for primary care, including preventive services, coronary  
305.16 artery and heart disease, diabetes, asthma, depression, and other measures as determined  
305.17 by the commissioner.

305.18 (b) Effective July 1, 2016, the commissioner shall stratify five quality measures by  
305.19 race, ethnicity, preferred language, and country of origin. On or after January 1, 2018, the  
305.20 commissioner may require measures to be stratified by other sociodemographic factors  
305.21 that according to reliable data are correlated with health disparities and have an impact  
305.22 on performance on quality or cost indicators. New methods of stratifying data under this  
305.23 paragraph must be tested and evaluated through pilot projects prior to adding them to the  
305.24 statewide system. In determining whether to add additional sociodemographic factors and  
305.25 developing the methodology to be used, the commissioner shall consider the reporting  
305.26 burden on providers and determine whether there are alternative sources of data that could  
305.27 be used. The commissioner shall ensure that categories and data collection methods are  
305.28 developed in consultation with those communities impacted by health disparities using  
305.29 culturally appropriate community engagement principles and methods. The commissioner  
305.30 shall implement this paragraph in coordination with the contracting entity retained under  
305.31 section 62U.02, subdivision 4, in order to build upon the data stratification methodology  
305.32 that has been developed and tested by the entity. Nothing in this paragraph expands or  
305.33 changes the commissioner's authority to collect, analyze, or report health care data. Any  
305.34 data collected to implement this paragraph must be data that is available or is authorized  
305.35 to be collected under other laws. Nothing in this paragraph grants authority to the

306.1 commissioner to collect or analyze patient-level or patient-specific data of the patient  
306.2 characteristics identified under this paragraph.

306.3 ~~(b)~~ (c) The measures shall be reviewed at least annually by the commissioner.

306.4 Sec. 34. Minnesota Statutes 2014, section 62U.02, subdivision 2, is amended to read:

306.5 Subd. 2. **Quality incentive payments.** (a) By July 1, 2009, the commissioner  
306.6 shall develop a system of quality incentive payments under which providers are eligible  
306.7 for quality-based payments that are in addition to existing payment levels, based upon  
306.8 a comparison of provider performance against specified targets, and improvement over  
306.9 time. The targets must be based upon and consistent with the quality measures established  
306.10 under subdivision 1.

306.11 (b) To the extent possible, the payment system must adjust for variations in patient  
306.12 population in order to reduce incentives to health care providers to avoid high-risk patients  
306.13 or populations, including those with risk factors related to race, ethnicity, language,  
306.14 country of origin, and sociodemographic factors.

306.15 (c) The requirements of section 62Q.101 do not apply under this incentive payment  
306.16 system.

306.17 Sec. 35. Minnesota Statutes 2014, section 62U.02, subdivision 3, is amended to read:

306.18 Subd. 3. **Quality transparency.** (a) The commissioner shall establish standards for  
306.19 measuring health outcomes, establish a system for risk adjusting quality measures, and  
306.20 issue annual public reports on provider quality beginning July 1, 2010.

306.21 (b) Effective July 1, 2017, the risk adjustment system established under this  
306.22 subdivision shall adjust for patient characteristics identified under subdivision 1, paragraph  
306.23 (b), that are correlated with health disparities and have an impact on performance on cost  
306.24 and quality measures. The risk adjustment method may consist of reporting based on an  
306.25 actual-to-expected comparison that reflects the characteristics of the patient population  
306.26 served by the clinic or hospital. The commissioner shall implement this paragraph in  
306.27 coordination with any contracting entity retained under section 62U.02, subdivision 4.

306.28 (c) By January 1, 2010, physician clinics and hospitals shall submit standardized  
306.29 electronic information on the outcomes and processes associated with patient care to  
306.30 the commissioner or the commissioner's designee. In addition to measures of care  
306.31 processes and outcomes, the report may include other measures designated by the  
306.32 commissioner, including, but not limited to, care infrastructure and patient satisfaction.  
306.33 The commissioner shall ensure that any quality data reporting requirements established  
306.34 under this subdivision are not duplicative of publicly reported, communitywide quality

307.1 reporting activities currently under way in Minnesota. Nothing in this subdivision is  
307.2 intended to replace or duplicate current privately supported activities related to quality  
307.3 measurement and reporting in Minnesota.

307.4 Sec. 36. Minnesota Statutes 2014, section 62U.02, subdivision 4, is amended to read:

307.5 Subd. 4. **Contracting.** The commissioner may contract with a private entity or  
307.6 consortium of private entities to complete the tasks in subdivisions 1 to 3. The private  
307.7 entity or consortium must be nonprofit and have governance that includes representatives  
307.8 from the following stakeholder groups: health care providers, including providers serving  
307.9 high concentrations of patients and communities impacted by health disparities; health  
307.10 plan companies; consumers, including consumers representing groups who experience  
307.11 health disparities; employers or other health care purchasers; and state government. No  
307.12 one stakeholder group shall have a majority of the votes on any issue or hold extraordinary  
307.13 powers not granted to any other governance stakeholder.

307.14 Sec. 37. Minnesota Statutes 2014, section 144E.001, is amended by adding a  
307.15 subdivision to read:

307.16 Subd. 5h. **Community medical response emergency medical technician.**  
307.17 "Community medical response emergency medical technician" or "CEMT" means  
307.18 a person who is certified as an emergency medical technician, who is a member of a  
307.19 registered medical response unit under section 144E.275, and who meets the requirements  
307.20 for additional certification as a CEMT as specified in section 144E.275, subdivision 7.

307.21 Sec. 38. Minnesota Statutes 2014, section 144E.275, subdivision 1, is amended to read:

307.22 Subdivision 1. **Definition.** For purposes of this section, the following definitions  
307.23 apply:

307.24 (a) "Medical response unit" means an organized service recognized by a local  
307.25 political subdivision whose primary responsibility is to respond to medical emergencies to  
307.26 provide initial medical care before the arrival of a licensed ambulance service. Medical  
307.27 response units may also provide CEMT services as permitted under subdivision 7.

307.28 (b) "Specialized medical response unit" means an organized service recognized by a  
307.29 board-approved authority other than a local political subdivision that responds to medical  
307.30 emergencies as needed or as required by local procedure or protocol.

307.31 Sec. 39. Minnesota Statutes 2014, section 144E.275, is amended by adding a  
307.32 subdivision to read:

308.1 Subd. 7. **Community medical response emergency medical technician.** (a) To be  
308.2 eligible for certification by the board as a CEMT, an individual shall:

308.3 (1) be currently certified as an EMT or AEMT;

308.4 (2) have two years of service as an EMT or AEMT;

308.5 (3) be a member of a registered medical response unit as defined under this section;

308.6 (4) successfully complete a CEMT training program from a college or university that

308.7 has been approved by the board or accredited by a board-approved national accrediting

308.8 organization. The training must include clinical experience under the supervision of the

308.9 medical response unit medical director, an advanced practice registered nurse, a physician

308.10 assistant, or a public health nurse operating under the direct authority of a local unit

308.11 of government;

308.12 (5) successfully complete a training program that includes training in providing

308.13 culturally appropriate care; and

308.14 (6) complete a board-approved application form.

308.15 (b) A CEMT must practice in accordance with protocols and supervisory standards

308.16 established by the medical response unit medical director in accordance with section

308.17 144E.265.

308.18 (c) A CEMT may provide services within the CEMT skill set as approved by the

308.19 medical response unit medical director.

308.20 (d) A CEMT may provide episodic individual patient education and prevention

308.21 education but only as directed by a patient care plan developed by the patient's primary

308.22 physician, an advanced practice registered nurse, or a physician assistant, in conjunction

308.23 with the medical response unit medical director and relevant local health care providers.

308.24 The patient care plan must ensure that the services provided by the CEMT are consistent

308.25 with services offered by the patient's health care home, if one exists, that the patient

308.26 receives the necessary services, and that there is no duplication of services to the patient.

308.27 (e) A CEMT is subject to all certification, disciplinary, complaint, and other

308.28 regulatory requirements that apply to EMTs under this chapter.

308.29 (f) A CEMT may not provide services as defined in section 144A.471, subdivisions

308.30 6 and 7, except a CEMT may provide verbal or visual reminders to the patient to:

308.31 (1) take a regularly scheduled medication, but not to provide or bring the patient

308.32 medication; and

308.33 (2) follow regularly scheduled treatment or exercise plans.

308.34 Sec. 40. Minnesota Statutes 2014, section 151.58, subdivision 2, is amended to read:

309.1 Subd. 2. **Definitions.** For purposes of this section only, the terms defined in this  
309.2 subdivision have the meanings given.

309.3 (a) "Automated drug distribution system" or "system" means a mechanical system  
309.4 approved by the board that performs operations or activities, other than compounding or  
309.5 administration, related to the storage, packaging, or dispensing of drugs, and collects,  
309.6 controls, and maintains all required transaction information and records.

309.7 (b) "Health care facility" means a nursing home licensed under section 144A.02;  
309.8 a housing with services establishment registered under section 144D.01, subdivision 4,  
309.9 in which a home provider licensed under chapter 144A is providing centralized storage  
309.10 of medications; a boarding care home licensed under sections 144.50 to 144.58 that is  
309.11 providing centralized storage of medications; or a Minnesota sex offender program facility  
309.12 operated by the Department of Human Services.

309.13 (c) "Managing pharmacy" means a pharmacy licensed by the board that controls and  
309.14 is responsible for the operation of an automated drug distribution system.

309.15 Sec. 41. Minnesota Statutes 2014, section 151.58, subdivision 5, is amended to read:

309.16 Subd. 5. **Operation of automated drug distribution systems.** (a) The managing  
309.17 pharmacy and the pharmacist in charge are responsible for the operation of an automated  
309.18 drug distribution system.

309.19 (b) Access to an automated drug distribution system must be limited to pharmacy  
309.20 and nonpharmacy personnel authorized to procure drugs from the system, except that field  
309.21 service technicians may access a system located in a health care facility for the purposes of  
309.22 servicing and maintaining it while being monitored either by the managing pharmacy, or a  
309.23 licensed nurse within the health care facility. In the case of an automated drug distribution  
309.24 system that is not physically located within a licensed pharmacy, access for the purpose  
309.25 of procuring drugs shall be limited to licensed nurses. Each person authorized to access  
309.26 the system must be assigned an individual specific access code. Alternatively, access to  
309.27 the system may be controlled through the use of biometric identification procedures. A  
309.28 policy specifying time access parameters, including time-outs, logoffs, and lockouts,  
309.29 must be in place.

309.30 (c) For the purposes of this section only, the requirements of section 151.215 are met  
309.31 if the following clauses are met:

309.32 (1) a pharmacist employed by and working at the managing pharmacy, or at a  
309.33 pharmacy that is acting as a central services pharmacy for the managing pharmacy,  
309.34 pursuant to Minnesota Rules, part 6800.4075, must review, interpret, and approve all  
309.35 prescription drug orders before any drug is distributed from the system to be administered

310.1 to a patient. A pharmacy technician may perform data entry of prescription drug orders  
310.2 provided that a pharmacist certifies the accuracy of the data entry before the drug can  
310.3 be released from the automated drug distribution system. A pharmacist employed by  
310.4 and working at the managing pharmacy must certify the accuracy of the filling of any  
310.5 cassettes, canisters, or other containers that contain drugs that will be loaded into the  
310.6 automated drug distribution system, unless the filled cassettes, canisters, or containers  
310.7 have been provided by a repackager registered with the United States Food and Drug  
310.8 Administration and licensed by the board as a manufacturer; and

310.9 (2) when the automated drug dispensing system is located and used within the  
310.10 managing pharmacy, a pharmacist must personally supervise and take responsibility for all  
310.11 packaging and labeling associated with the use of an automated drug distribution system.

310.12 (d) Access to drugs when a pharmacist has not reviewed and approved the  
310.13 prescription drug order is permitted only when a formal and written decision to allow such  
310.14 access is issued by the pharmacy and the therapeutics committee or its equivalent. The  
310.15 committee must specify the patient care circumstances in which such access is allowed,  
310.16 the drugs that can be accessed, and the staff that are allowed to access the drugs.

310.17 (e) In the case of an automated drug distribution system that does not utilize bar  
310.18 coding in the loading process, the loading of a system located in a health care facility may  
310.19 be performed by a pharmacy technician, so long as the activity is continuously supervised,  
310.20 through a two-way audiovisual system by a pharmacist on duty within the managing  
310.21 pharmacy. In the case of an automated drug distribution system that utilizes bar coding  
310.22 in the loading process, the loading of a system located in a health care facility may be  
310.23 performed by a pharmacy technician or a licensed nurse, provided that the managing  
310.24 pharmacy retains an electronic record of loading activities.

310.25 (f) The automated drug distribution system must be under the supervision of a  
310.26 pharmacist. The pharmacist is not required to be physically present at the site of the  
310.27 automated drug distribution system if the system is continuously monitored electronically  
310.28 by the managing pharmacy. A pharmacist on duty within a pharmacy licensed by the  
310.29 board must be continuously available to address any problems detected by the monitoring  
310.30 or to answer questions from the staff of the health care facility. The licensed pharmacy  
310.31 may be the managing pharmacy or a pharmacy which is acting as a central services  
310.32 pharmacy, pursuant to Minnesota Rules, part 6800.4075, for the managing pharmacy.

310.33 Sec. 42. Minnesota Statutes 2014, section 256B.0625, subdivision 3b, is amended to  
310.34 read:

311.1 Subd. 3b. **Telemedicine consultations services.** (a) Medical assistance covers  
311.2 medically necessary services and consultations delivered by a licensed health care provider  
311.3 via telemedicine consultations. Telemedicine consultations must be made via two-way,  
311.4 interactive video or store-and-forward technology. Store-and-forward technology includes  
311.5 telemedicine consultations that do not occur in real time via synchronous transmissions,  
311.6 and that do not require a face-to-face encounter with the patient for all or any part of any  
311.7 such telemedicine consultation. The patient record must include a written opinion from the  
311.8 consulting physician providing the telemedicine consultation. A communication between  
311.9 two physicians that consists solely of a telephone conversation is not a telemedicine  
311.10 consultation in the same manner as if the service or consultation was delivered in person.  
311.11 Coverage is limited to three telemedicine consultations services per recipient enrollee per  
311.12 calendar week. Telemedicine consultations services shall be paid at the full allowable rate.

311.13 (b) The commissioner shall establish criteria that a health care provider must attest  
311.14 to in order to demonstrate the safety or efficacy of delivering a particular service via  
311.15 telemedicine. The attestation may include that the health care provider:

311.16 (1) has identified the categories or types of services the health care provider will  
311.17 provide via telemedicine;

311.18 (2) has written policies and procedures specific to telemedicine services that are  
311.19 regularly reviewed and updated;

311.20 (3) has policies and procedures that adequately address patient safety before, during,  
311.21 and after the telemedicine service is rendered;

311.22 (4) has established protocols addressing how and when to discontinue telemedicine  
311.23 services; and

311.24 (5) has an established quality assurance process related to telemedicine services.

311.25 (c) As a condition of payment, a licensed health care provider must document  
311.26 each occurrence of a health service provided by telemedicine to a medical assistance  
311.27 enrollee. Health care service records for services provided by telemedicine must meet  
311.28 the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and  
311.29 must document:

311.30 (1) the type of service provided by telemedicine;

311.31 (2) the time the service began and the time the service ended, including an a.m. and  
311.32 p.m. designation;

311.33 (3) the licensed health care provider's basis for determining that telemedicine is an  
311.34 appropriate and effective means for delivering the service to the enrollee;

311.35 (4) the mode of transmission of the telemedicine service and records evidencing that  
311.36 a particular mode of transmission was utilized;

312.1 (5) the location of the originating site and the distant site;

312.2 (6) if the claim for payment is based on a physician's telemedicine consultation  
 312.3 with another physician, the written opinion from the consulting physician providing the  
 312.4 telemedicine consultation; and

312.5 (7) compliance with the criteria attested to by the health care provider in accordance  
 312.6 with paragraph (b).

312.7 (d) If a health care provider provides the facility used as the originating site for the  
 312.8 delivery of telemedicine to a patient, the commissioner shall make a facility fee payment  
 312.9 to the originating site health care provider in an amount equivalent to the originated site  
 312.10 fee paid by Medicare. No facility fee shall be paid to a health care provider that is being  
 312.11 paid under a cost-based methodology or if Medicare has already paid the facility fee for an  
 312.12 enrollee who is dually eligible for Medicare and medical assistance.

312.13 (e) For purposes of this subdivision, "telemedicine" is defined under section  
 312.14 62A.671, subdivision 9; "licensed health care provider" is defined under section 62A.671,  
 312.15 subdivision 6; "health care provider" is defined under section 62A.671, subdivision 3; and  
 312.16 "originating site" is defined under section 62A.671, subdivision 7.

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

312.18 Sec. 43. Minnesota Statutes 2014, section 256B.0625, subdivision 13, is amended to  
 312.19 read:

312.20 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs  
 312.21 when specifically used to enhance fertility, if prescribed by a licensed practitioner and  
 312.22 dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance  
 312.23 program as a dispensing physician, or by a physician, physician assistant, or a nurse  
 312.24 practitioner employed by or under contract with a community health board as defined in  
 312.25 section 145A.02, subdivision 5, for the purposes of communicable disease control.

312.26 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,  
 312.27 unless authorized by the commissioner.

312.28 (c) For the purpose of this subdivision and subdivision 13d, an "active  
 312.29 pharmaceutical ingredient" is defined as a substance that is represented for use in a drug  
 312.30 and when used in the manufacturing, processing, or packaging of a drug becomes an  
 312.31 active ingredient of the drug product. An "excipient" is defined as an inert substance  
 312.32 used as a diluent or vehicle for a drug. The commissioner shall establish a list of active  
 312.33 pharmaceutical ingredients and excipients which are included in the medical assistance  
 312.34 formulary. Medical assistance covers selected active pharmaceutical ingredients and



313.1 excipients used in compounded prescriptions when the compounded combination is  
313.2 specifically approved by the commissioner or when a commercially available product:

313.3 (1) is not a therapeutic option for the patient;

313.4 (2) does not exist in the same combination of active ingredients in the same strengths  
313.5 as the compounded prescription; and

313.6 (3) cannot be used in place of the active pharmaceutical ingredient in the  
313.7 compounded prescription.

313.8 (d) Medical assistance covers the following over-the-counter drugs when prescribed  
313.9 by a licensed practitioner or by a licensed pharmacist who meets standards established by  
313.10 the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen,  
313.11 family planning products, aspirin, insulin, products for the treatment of lice, vitamins for  
313.12 adults with documented vitamin deficiencies, vitamins for children under the age of seven  
313.13 and pregnant or nursing women, and any other over-the-counter drug identified by the  
313.14 commissioner, in consultation with the formulary committee, as necessary, appropriate,  
313.15 and cost-effective for the treatment of certain specified chronic diseases, conditions,  
313.16 or disorders, and this determination shall not be subject to the requirements of chapter  
313.17 14. A pharmacist may prescribe over-the-counter medications as provided under this  
313.18 paragraph for purposes of receiving reimbursement under Medicaid. When prescribing  
313.19 over-the-counter drugs under this paragraph, licensed pharmacists must consult with  
313.20 the recipient to determine necessity, provide drug counseling, review drug therapy  
313.21 for potential adverse interactions, and make referrals as needed to other health care  
313.22 professionals. Over-the-counter medications must be dispensed in a quantity that is the  
313.23 ~~lower~~ lowest of: (1) the number of dosage units contained in the manufacturer's original  
313.24 package; ~~and~~ (2) the number of dosage units required to complete the patient's course of  
313.25 therapy; or (3) if applicable, the number of dosage units dispensed from a system using  
313.26 retrospective billing, as provided under subdivision 13e, paragraph (b).

313.27 (e) Effective January 1, 2006, medical assistance shall not cover drugs that  
313.28 are coverable under Medicare Part D as defined in the Medicare Prescription Drug,  
313.29 Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e),  
313.30 for individuals eligible for drug coverage as defined in the Medicare Prescription  
313.31 Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section  
313.32 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the  
313.33 drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this  
313.34 subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code,  
313.35 title 42, section 1396r-8(d)(2)(E), shall not be covered.

314.1 (f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing  
314.2 Program and dispensed by 340B covered entities and ambulatory pharmacies under  
314.3 common ownership of the 340B covered entity. Medical assistance does not cover drugs  
314.4 acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract  
314.5 pharmacies.

314.6 **EFFECTIVE DATE.** This section is effective January 1, 2016, or upon federal  
314.7 approval, whichever is later.

314.8 Sec. 44. Minnesota Statutes 2014, section 256B.0625, subdivision 13e, is amended to  
314.9 read:

314.10 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment  
314.11 shall be the lower of the actual acquisition costs of the drugs or the maximum allowable  
314.12 cost by the commissioner plus the fixed dispensing fee; or the usual and customary price  
314.13 charged to the public. The amount of payment basis must be reduced to reflect all discount  
314.14 amounts applied to the charge by any provider/insurer agreement or contract for submitted  
314.15 charges to medical assistance programs. The net submitted charge may not be greater  
314.16 than the patient liability for the service. The pharmacy dispensing fee shall be \$3.65  
314.17 for legend prescription drugs, except that the dispensing fee for intravenous solutions  
314.18 which must be compounded by the pharmacist shall be \$8 per bag, \$14 per bag for cancer  
314.19 chemotherapy products, and \$30 per bag for total parenteral nutritional products dispensed  
314.20 in one liter quantities, or \$44 per bag for total parenteral nutritional products dispensed in  
314.21 quantities greater than one liter. The pharmacy dispensing fee for over the counter drugs  
314.22 shall be \$3.65, except that the fee shall be \$1.31 for retrospectively billing pharmacies  
314.23 when billing for quantities less than the number of units contained in the manufacturer's  
314.24 original package. Actual acquisition cost includes quantity and other special discounts  
314.25 except time and cash discounts. The actual acquisition cost of a drug shall be estimated  
314.26 by the commissioner at wholesale acquisition cost plus four percent for independently  
314.27 owned pharmacies located in a designated rural area within Minnesota, and at wholesale  
314.28 acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently  
314.29 owned" if it is one of four or fewer pharmacies under the same ownership nationally. A  
314.30 "designated rural area" means an area defined as a small rural area or isolated rural area  
314.31 according to the four-category classification of the Rural Urban Commuting Area system  
314.32 developed for the United States Health Resources and Services Administration. Effective  
314.33 January 1, 2014, the actual acquisition cost of a drug acquired through the federal 340B  
314.34 Drug Pricing Program shall be estimated by the commissioner at wholesale acquisition  
314.35 cost minus 40 percent. Wholesale acquisition cost is defined as the manufacturer's list

315.1 price for a drug or biological to wholesalers or direct purchasers in the United States, not  
315.2 including prompt pay or other discounts, rebates, or reductions in price, for the most  
315.3 recent month for which information is available, as reported in wholesale price guides or  
315.4 other publications of drug or biological pricing data. The maximum allowable cost of a  
315.5 multisource drug may be set by the commissioner and it shall be comparable to, but no  
315.6 higher than, the maximum amount paid by other third-party payors in this state who have  
315.7 maximum allowable cost programs. Establishment of the amount of payment for drugs  
315.8 shall not be subject to the requirements of the Administrative Procedure Act.

315.9 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities  
315.10 using an automated drug distribution system meeting the requirements of section 151.58,  
315.11 or a packaging system meeting the packaging standards set forth in Minnesota Rules, part  
315.12 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ  
315.13 retrospective billing for prescription drugs dispensed to long-term care facility residents.  
315.14 A retrospectively billing pharmacy must submit a claim only for the quantity of medication  
315.15 used by the enrolled recipient during the defined billing period. A retrospectively billing  
315.16 pharmacy must use a billing period not less than one calendar month or 30 days.

315.17 (c) An additional dispensing fee of \$.30 may be added to the dispensing fee paid to  
315.18 pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities  
315.19 when a unit dose blister card system, approved by the department, is used. Under this type  
315.20 of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National  
315.21 Drug Code (NDC) from the drug container used to fill the blister card must be identified on  
315.22 the claim to the department. The unit dose blister card containing the drug must meet the  
315.23 packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of  
315.24 unused drugs to the pharmacy for reuse. The A pharmacy provider will be using packaging  
315.25 that meets the standards set forth in Minnesota Rules, part 6800.2700, is required to credit  
315.26 the department for the actual acquisition cost of all unused drugs that are eligible for reuse,  
315.27 unless the pharmacy is using retrospective billing. The commissioner may permit the drug  
315.28 clozapine to be dispensed in a quantity that is less than a 30-day supply.

315.29 (e) (d) Whenever a maximum allowable cost has been set for a multisource drug,  
315.30 payment shall be the lower of the usual and customary price charged to the public or the  
315.31 maximum allowable cost established by the commissioner unless prior authorization  
315.32 for the brand name product has been granted according to the criteria established by  
315.33 the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the  
315.34 prescriber has indicated "dispense as written" on the prescription in a manner consistent  
315.35 with section 151.21, subdivision 2.

316.1           ~~(d)~~ (e) The basis for determining the amount of payment for drugs administered in  
316.2 an outpatient setting shall be the lower of the usual and customary cost submitted by  
316.3 the provider, 106 percent of the average sales price as determined by the United States  
316.4 Department of Health and Human Services pursuant to title XVIII, section 1847a of the  
316.5 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost  
316.6 set by the commissioner. If average sales price is unavailable, the amount of payment  
316.7 must be lower of the usual and customary cost submitted by the provider, the wholesale  
316.8 acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the  
316.9 commissioner. Effective January 1, 2014, the commissioner shall discount the payment  
316.10 rate for drugs obtained through the federal 340B Drug Pricing Program by 20 percent. The  
316.11 payment for drugs administered in an outpatient setting shall be made to the administering  
316.12 facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration  
316.13 in an outpatient setting is not eligible for direct reimbursement.

316.14           ~~(e)~~ (f) The commissioner may negotiate lower reimbursement rates for specialty  
316.15 pharmacy products than the rates specified in paragraph (a). The commissioner may  
316.16 require individuals enrolled in the health care programs administered by the department  
316.17 to obtain specialty pharmacy products from providers with whom the commissioner has  
316.18 negotiated lower reimbursement rates. Specialty pharmacy products are defined as those  
316.19 used by a small number of recipients or recipients with complex and chronic diseases  
316.20 that require expensive and challenging drug regimens. Examples of these conditions  
316.21 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis  
316.22 C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms  
316.23 of cancer. Specialty pharmaceutical products include injectable and infusion therapies,  
316.24 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies  
316.25 that require complex care. The commissioner shall consult with the formulary committee  
316.26 to develop a list of specialty pharmacy products subject to this paragraph. In consulting  
316.27 with the formulary committee in developing this list, the commissioner shall take into  
316.28 consideration the population served by specialty pharmacy products, the current delivery  
316.29 system and standard of care in the state, and access to care issues. The commissioner shall  
316.30 have the discretion to adjust the reimbursement rate to prevent access to care issues.

316.31           ~~(f)~~ (g) Home infusion therapy services provided by home infusion therapy  
316.32 pharmacies must be paid at rates according to subdivision 8d.

316.33           **EFFECTIVE DATE.** This section is effective January 1, 2016, or upon federal  
316.34 approval, whichever is later.

317.1 Sec. 45. Minnesota Statutes 2014, section 256B.072, is amended to read:

317.2 **256B.072 PERFORMANCE REPORTING AND QUALITY IMPROVEMENT**  
317.3 **SYSTEM.**

317.4 (a) The commissioner of human services shall establish a performance reporting  
317.5 system for health care providers who provide health care services to public program  
317.6 recipients covered under chapters 256B, 256D, and 256L, reporting separately for  
317.7 managed care and fee-for-service recipients.

317.8 (b) The measures used for the performance reporting system for medical groups  
317.9 shall include measures of care for asthma, diabetes, hypertension, and coronary artery  
317.10 disease and measures of preventive care services. The measures used for the performance  
317.11 reporting system for inpatient hospitals shall include measures of care for acute myocardial  
317.12 infarction, heart failure, and pneumonia, and measures of care and prevention of surgical  
317.13 infections. In the case of a medical group, the measures used shall be consistent with  
317.14 measures published by nonprofit Minnesota or national organizations that produce and  
317.15 disseminate health care quality measures or evidence-based health care guidelines. In  
317.16 the case of inpatient hospital measures, the commissioner shall appoint the Minnesota  
317.17 Hospital Association and Stratis Health to advise on the development of the performance  
317.18 measures to be used for hospital reporting. To enable a consistent measurement process  
317.19 across the community, the commissioner may use measures of care provided for patients in  
317.20 addition to those identified in paragraph (a). The commissioner shall ensure collaboration  
317.21 with other health care reporting organizations so that the measures described in this  
317.22 section are consistent with those reported by those organizations and used by other  
317.23 purchasers in Minnesota.

317.24 (c) The commissioner may require providers to submit information in a required  
317.25 format to a health care reporting organization or to cooperate with the information collection  
317.26 procedures of that organization. The commissioner may collaborate with a reporting  
317.27 organization to collect information reported and to prevent duplication of reporting.

317.28 (d) By October 1, 2007, and annually thereafter, the commissioner shall report  
317.29 through a public Web site the results by medical groups and hospitals, where possible,  
317.30 of the measures under this section, and shall compare the results by medical groups and  
317.31 hospitals for patients enrolled in public programs to patients enrolled in private health  
317.32 plans. To achieve this reporting, the commissioner may collaborate with a health care  
317.33 reporting organization that operates a Web site suitable for this purpose.

317.34 (e) Performance measures must be stratified as provided under section 62U.02,  
317.35 subdivision 1, paragraph (b), and risk-adjusted as specified in section 62U.02, subdivision  
317.36 3, paragraph (b).

318.1 Sec. 46. Minnesota Statutes 2014, section 256B.69, subdivision 6, is amended to read:

318.2 Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for  
318.3 the health care coordination for eligible individuals. Demonstration providers:

318.4 (1) shall authorize and arrange for the provision of all needed health services  
318.5 including but not limited to the full range of services listed in sections 256B.02,  
318.6 subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to  
318.7 enrollees. Notwithstanding section 256B.0621, demonstration providers that provide  
318.8 nursing home and community-based services under this section shall provide relocation  
318.9 service coordination to enrolled persons age 65 and over;

318.10 (2) shall accept the prospective, per capita payment from the commissioner in return  
318.11 for the provision of comprehensive and coordinated health care services for eligible  
318.12 individuals enrolled in the program;

318.13 (3) may contract with other health care and social service practitioners to provide  
318.14 services to enrollees; and

318.15 (4) shall institute recipient grievance procedures according to the method established  
318.16 by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved  
318.17 through this process shall be appealable to the commissioner as provided in subdivision 11.

318.18 (b) Demonstration providers must comply with the standards for claims settlement  
318.19 under section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health  
318.20 care and social service practitioners to provide services to enrollees. A demonstration  
318.21 provider must pay a clean claim, as defined in Code of Federal Regulations, title 42,  
318.22 section 447.45(b), within 30 business days of the date of acceptance of the claim.

318.23 (c) Managed care plans and county-based purchasing plans must comply with  
318.24 chapter 62M and section 62Q.85.

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

318.26 Sec. 47. **PRESCRIPTION DRUG ADVISORY COUNCIL.**

318.27 The commissioner of health shall make the first appointments to the Prescription  
318.28 Drug Advisory Council established in Minnesota Statutes, section 62Q.85, subdivision 6,  
318.29 by October 2, 2015, and convene the first meeting by November 1, 2015. The council  
318.30 shall select a chair from among its members at the first meeting of the council.

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

319.1       Sec. 48. **PROPOSAL FOR CHILD PROTECTION FOCUSED "COMMUNITY**  
319.2 **MEDICAL RESPONSE EMERGENCY MEDICAL TECHNICIAN" (CEMT)**  
319.3 **MODEL.**

319.4       The commissioner shall develop a proposal for a pilot project to create a  
319.5 community-based support system that coordinates services between child protection  
319.6 services and community emergency medical technicians. This pilot project model shall  
319.7 be developed with the input of stakeholders that represent both child protection services  
319.8 and community emergency medical technicians. The model must be designed so that the  
319.9 collaborative effort results in increased safety for children and increased support for  
319.10 families. The pilot project model must be reviewed by the Task Force on the Protection of  
319.11 Children, and the commissioner shall make recommendations for the pilot project to the  
319.12 members of the legislative committees with primary jurisdiction over CEMT and child  
319.13 protection issues no later than January 15, 2016.

319.14       Sec. 49. **COMMUNITY MEDICAL RESPONSE EMERGENCY MEDICAL**  
319.15 **TECHNICIAN SERVICES COVERED UNDER THE MEDICAL ASSISTANCE**  
319.16 **PROGRAM.**

319.17       (a) The commissioner of human services, in consultation with representatives of  
319.18 emergency medical service providers, public health nurses, community health workers,  
319.19 the Minnesota State Fire Chiefs Association, the Minnesota Professional Firefighters  
319.20 Association, the Minnesota State Firefighters Department Association, Minnesota  
319.21 Academy of Family Physicians, Minnesota Licensed Practical Nurses Association,  
319.22 Minnesota Nurses Association, and local public health agencies, shall determine specified  
319.23 services and payment rates for these services to be performed by community medical  
319.24 response emergency medical technicians certified under Minnesota Statutes, section  
319.25 144E.275, subdivision 7, and covered by medical assistance under Minnesota Statutes,  
319.26 section 256B.0625. Services must be in the CEMT skill set and may include interventions  
319.27 intended to prevent avoidable ambulance transportation or hospital emergency department  
319.28 use.

319.29       (b) In order to be eligible for payment, services provided by a community medical  
319.30 response emergency medical technician must be:

319.31       (1) ordered by a medical response unit medical director;

319.32       (2) part of a patient care plan that has been developed in coordination with the  
319.33 patient's primary physician, advanced practice registered nurse, and relevant local health  
319.34 care providers; and

320.1 (3) billed by an eligible medical assistance enrolled provider that employs or  
 320.2 contracts with the community medical response emergency medical technician.

320.3 In determining the community medical response emergency medical technician services  
 320.4 to include under medical assistance coverage, the commissioner of human services shall  
 320.5 consider the potential of hospital admittance and emergency room utilization reductions as  
 320.6 well as increased access to quality care in rural communities.

320.7 (c) The commissioner of human services shall submit the list of services to be  
 320.8 covered by medical assistance to the chairs and ranking minority members of the  
 320.9 legislative committees with jurisdiction over health and human services policy and  
 320.10 spending by February 15, 2016. These services shall not be covered by medical assistance  
 320.11 until legislation providing coverage for the services is enacted in law.

320.12 Sec. 50. **EVALUATION OF COMMUNITY MEDICAL RESPONSE**  
 320.13 **EMERGENCY MEDICAL TECHNICIAN SERVICES.**

320.14 If legislation is enacted to cover community medical response emergency medical  
 320.15 technician services with medical assistance, the commissioner of human services shall  
 320.16 evaluate the effect of medical assistance and MinnesotaCare coverage for those services  
 320.17 on the cost and quality of care under those programs and the coordination of those services  
 320.18 with the health care home services. The commissioner shall present findings to the chairs  
 320.19 and ranking minority members of the legislative committees with jurisdiction over health  
 320.20 and human services policy and spending by December 1, 2017. The commissioner shall  
 320.21 require medical assistance and MinnesotaCare enrolled providers that employ or contract  
 320.22 with community medical response emergency medical technicians to provide to the  
 320.23 commissioner, in the form and manner specified by the commissioner, the utilization, cost,  
 320.24 and quality data necessary to conduct this evaluation.

320.25 Sec. 51. **REVISOR INSTRUCTION.**

320.26 The revisor of statutes shall change "sections 62M.01 to 62M.16" to "sections  
 320.27 62M.01 to 62M.17" wherever the term appears in Minnesota Statutes, chapter 62M.

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

320.29 **ARTICLE 9**

320.30 **HEALTH LICENSING BOARDS**

320.31 Section 1. Minnesota Statutes 2014, section 148.57, subdivision 1, is amended to read:



321.1 Subdivision 1. **Examination.** (a) A person not authorized to practice optometry in  
321.2 the state and desiring to do so shall apply to the state Board of Optometry by filling out  
321.3 and swearing to an application for a license granted by the board and accompanied by a  
321.4 fee ~~in an amount of \$87~~ established by the board, not to exceed the amount specified in  
321.5 section 148.59. With the submission of the application form, the candidate shall prove  
321.6 that the candidate:

321.7 (1) is of good moral character;

321.8 (2) has obtained a clinical doctorate degree from a board-approved school or college  
321.9 of optometry, or is currently enrolled in the final year of study at such an institution; and

321.10 (3) has passed all parts of an examination.

321.11 (b) The examination shall include both a written portion and a clinical practical  
321.12 portion and shall thoroughly test the fitness of the candidate to practice in this state. In  
321.13 regard to the written and clinical practical examinations, the board may:

321.14 (1) prepare, administer, and grade the examination itself;

321.15 (2) recognize and approve in whole or in part an examination prepared, administered  
321.16 and graded by a national board of examiners in optometry; or

321.17 (3) administer a recognized and approved examination prepared and graded by or  
321.18 under the direction of a national board of examiners in optometry.

321.19 (c) The board shall issue a license to each applicant who satisfactorily passes the  
321.20 examinations and fulfills the other requirements stated in this section and section 148.575  
321.21 for board certification for the use of legend drugs. Applicants for initial licensure do not  
321.22 need to apply for or possess a certificate as referred to in sections 148.571 to 148.574. The  
321.23 fees mentioned in this section are for the use of the board and in no case shall be refunded.

321.24 Sec. 2. Minnesota Statutes 2014, section 148.57, subdivision 2, is amended to read:

321.25 Subd. 2. **Endorsement.** An optometrist who holds a current license from another  
321.26 state, and who has practiced in that state not less than three years immediately preceding  
321.27 application, may apply for licensure in Minnesota by filling out and swearing to an  
321.28 application for license by endorsement furnished by the board. The completed application  
321.29 with all required documentation shall be filed at the board office along with a fee ~~of \$87~~  
321.30 established by the board, not to exceed the amount specified in section 148.59. The  
321.31 application fee shall be for the use of the board and in no case shall be refunded. To  
321.32 verify that the applicant possesses the knowledge and ability essential to the practice of  
321.33 optometry in this state, the applicant must provide evidence of:

321.34 (1) having obtained a clinical doctorate degree from a board-approved school  
321.35 or college of optometry;

322.1 (2) successful completion of both written and practical examinations for licensure in  
 322.2 the applicant's original state of licensure that thoroughly tested the fitness of the applicant  
 322.3 to practice;

322.4 (3) successful completion of an examination of Minnesota state optometry laws;

322.5 (4) compliance with the requirements for board certification in section 148.575;

322.6 (5) compliance with all continuing education required for license renewal in every  
 322.7 state in which the applicant currently holds an active license to practice; and

322.8 (6) being in good standing with every state board from which a license has been  
 322.9 issued.

322.10 Documentation from a national certification system or program, approved by the  
 322.11 board, which supports any of the listed requirements, may be used as evidence. The  
 322.12 applicant may then be issued a license if the requirements for licensure in the other state  
 322.13 are deemed by the board to be equivalent to those of sections 148.52 to 148.62.

322.14 Sec. 3. Minnesota Statutes 2014, section 148.59, is amended to read:

322.15 **148.59 LICENSE RENEWAL; ~~FEE~~ LICENSE AND REGISTRATION FEES.**

322.16 A licensed optometrist shall pay to the state Board of Optometry a fee as set by the  
 322.17 board in order to renew a license as provided by board rule. No fees shall be refunded.

322.18 Fees may not exceed the following amounts but may be adjusted lower by board direction  
 322.19 and are for the exclusive use of the board:

322.20 (1) optometry licensure application, \$160;

322.21 (2) optometry annual licensure renewal, \$135;

322.22 (3) optometry late penalty fee, \$75;

322.23 (4) annual license renewal card, \$10;

322.24 (5) continuing education provider application, \$45;

322.25 (6) emeritus registration, \$10;

322.26 (7) endorsement/reciprocity application, \$160;

322.27 (8) replacement of initial license, \$12; and

322.28 (9) license verification, \$50.

322.29 Sec. 4. Minnesota Statutes 2014, section 148E.075, is amended to read:

322.30 **148E.075 ~~INACTIVE LICENSES~~ ALTERNATE LICENSES.**

322.31 Subdivision 1. ~~Inactive status~~ Temporary leave license. (a) ~~A licensee qualifies~~  
 322.32 ~~for inactive status under either of the circumstances described in paragraph (b) or (c).~~

322.33 (b) ~~A licensee qualifies for inactive status when the licensee is granted temporary~~  
 322.34 ~~leave from active practice.~~ A licensee qualifies for temporary leave from active practice if

323.1 the licensee demonstrates to the satisfaction of the board that the licensee is not engaged  
323.2 in the practice of social work in any setting, including settings in which social workers are  
323.3 exempt from licensure according to section 148E.065. A licensee who is granted temporary  
323.4 leave from active practice may reactivate the license according to section 148E.080.

323.5 (b) A licensee may maintain a temporary leave license for no more than four  
323.6 consecutive years.

323.7 ~~(e) A licensee qualifies for inactive status when a licensee is granted an emeritus~~  
323.8 ~~license. A licensee qualifies for an emeritus license if the licensee demonstrates to the~~  
323.9 ~~satisfaction of the board that:~~

323.10 ~~(1) the licensee is retired from social work practice; and~~

323.11 ~~(2) the licensee is not engaged in the practice of social work in any setting, including~~  
323.12 ~~settings in which social workers are exempt from licensure according to section 148E.065.~~

323.13 ~~A licensee who possesses an emeritus license may reactivate the license according to~~  
323.14 ~~section 148E.080.~~

323.15 (c) A licensee who is granted temporary leave from active practice may reactivate  
323.16 the license according to section 148E.080. If a licensee does not apply for reactivation  
323.17 within 60 days following the end of the consecutive four-year period, the license  
323.18 automatically expires. An individual with an expired license may apply for new licensure  
323.19 according to section 148E.055.

323.20 (d) Except as provided in paragraph (e), a licensee who holds a temporary leave  
323.21 license must not practice, attempt to practice, offer to practice, or advertise or hold out as  
323.22 authorized to practice social work.

323.23 (e) The board may grant a variance to the requirements of paragraph (d) if a licensee  
323.24 on temporary leave license provides emergency social work services. A variance is  
323.25 granted only if the board provides the variance in writing to the licensee. The board may  
323.26 impose conditions or restrictions on the variance.

323.27 (f) In making representations of professional status to the public, when holding a  
323.28 temporary leave license, a licensee must state that the license is not active and that the  
323.29 licensee cannot practice social work.

323.30 Subd. 1a. **Emeritus inactive license.** (a) A licensee qualifies for an emeritus inactive  
323.31 license if the licensee demonstrates to the satisfaction of the board that the licensee is:

323.32 (1) retired from social work practice; and

323.33 (2) not engaged in the practice of social work in any setting, including settings in  
323.34 which social workers are exempt from licensure according to section 148E.065.

323.35 (b) A licensee with an emeritus inactive license may apply for reactivation according  
323.36 to section 148E.080 only during the four years following the granting of the emeritus

324.1 inactive license. However, after four years following the granting of the emeritus inactive  
324.2 license, an individual may apply for new licensure according to section 148E.055.

324.3 (c) Except as provided in paragraph (d), a licensee who holds an emeritus inactive  
324.4 license must not practice, attempt to practice, offer to practice, or advertise or hold out as  
324.5 authorized to practice social work.

324.6 (d) The board may grant a variance to the requirements of paragraph (c) if a licensee  
324.7 on emeritus inactive license provides emergency social work services. A variance is  
324.8 granted only if the board provides the variance in writing to the licensee. The board may  
324.9 impose conditions or restrictions on the variance.

324.10 (e) In making representations of professional status to the public, when holding  
324.11 an emeritus inactive license, a licensee must state that the license is not active and that  
324.12 the licensee cannot practice social work.

324.13 Subd. 1b. **Emeritus active license.** (a) A licensee qualifies for an emeritus active  
324.14 license if the applicant demonstrates to the satisfaction of the board that the licensee is:

324.15 (1) retired from social work practice; and

324.16 (2) in compliance with the supervised practice requirements, as applicable, under  
324.17 sections 148E.100 to 148E.125.

324.18 (b) A licensee who is issued an emeritus active license is only authorized to engage in:

324.19 (1) pro bono or unpaid social work practice as specified in section 148E.010,  
324.20 subdivisions 6 and 11; or

324.21 (2) paid social work practice not to exceed 240 clock hours per calendar year, for the  
324.22 exclusive purpose of providing licensing supervision as specified in sections 148E.100 to  
324.23 148E.125; and

324.24 (3) the authorized scope of practice specified in section 148E.050.

324.25 (c) An emeritus active license must be renewed according to the requirements  
324.26 specified in section 148E.070, subdivisions 1, 2, 3, 4, and 5.

324.27 (d) At the time of license renewal a licensee must provide evidence satisfactory to the  
324.28 board that the licensee has, during the renewal term, completed 20 clock hours of continuing  
324.29 education, including at least two clock hours in ethics, as specified in section 148E.130:

324.30 (1) for licensed independent clinical social workers, at least 12 clock hours must be  
324.31 in the clinical content areas specified in section 148E.055, subdivision 5; and

324.32 (2) for social workers providing supervision according to sections 148E.100 to  
324.33 148E.125, at least three clock hours must be in the practice of supervision.

324.34 (e) Independent study hours must not consist of more than eight clock hours of  
324.35 continuing education per renewal term.

325.1 (f) Failure to renew an active emeritus license on the expiration date will result in an  
325.2 expired license as specified in section 148E.070, subdivision 5.

325.3 (g) The board may grant a variance to the requirements of paragraph (b) if a licensee  
325.4 holding an emeritus active license provides emergency social work services. A variance is  
325.5 granted only if the board provides the variance in writing to the licensee. The board may  
325.6 impose conditions or restrictions on the variance.

325.7 (h) In making representations of professional status to the public, when holding an  
325.8 emeritus active license, a licensee must state that an emeritus active license authorizes  
325.9 only pro bono or unpaid social work practice, or paid social work practice not to exceed  
325.10 240 clock hours per calendar year, for the exclusive purpose of providing licensing  
325.11 supervision as specified in sections 148E.100 to 148E.125.

325.12 (i) Notwithstanding the time limit and emeritus active license renewal requirements  
325.13 specified in this section, a licensee who possesses an emeritus active license may  
325.14 reactivate the license according to section 148E.080 or apply for new licensure according  
325.15 to section 148E.055.

325.16 Subd. 2. **Application.** A licensee may apply for ~~inactive status~~ temporary leave  
325.17 license, emeritus inactive license, or emeritus active license:

325.18 (1) at any time when currently licensed under section 148E.055, 148E.0555,  
325.19 148E.0556, or 148E.0557, or when licensed as specified in section 148E.075, by  
325.20 submitting an application for a temporary leave from active practice or for an emeritus  
325.21 license form required by the board; or

325.22 (2) as an alternative to applying for the renewal of a license by so recording on the  
325.23 application for license renewal form required by the board and submitting the completed,  
325.24 signed application to the board.

325.25 An application that is not completed or signed, or that is not accompanied by the  
325.26 correct fee, must be returned to the applicant, along with any fee submitted, and is void.  
325.27 For applications submitted electronically, a "signed application" means providing an  
325.28 attestation as specified by the board.

325.29 Subd. 3. **Fee.** (a) Regardless of when the application for ~~inactive status~~ temporary  
325.30 leave license or emeritus inactive license is submitted, the temporary leave license or  
325.31 emeritus inactive license fee specified in section 148E.180, whichever is applicable, must  
325.32 accompany the application. A licensee who is approved for ~~inactive status~~ temporary  
325.33 leave license or emeritus inactive license before the license expiration date is not entitled  
325.34 to receive a refund for any portion of the license or renewal fee.

326.1 (b) If an application for temporary leave license or emeritus active license is received  
 326.2 after the license expiration date, the licensee must pay a renewal late fee as specified in  
 326.3 section 148E.180 in addition to the temporary leave fee.

326.4 (c) Regardless of when the application for emeritus active license is submitted,  
 326.5 the emeritus active license fee is one-half of the renewal fee for the applicable license  
 326.6 specified in section 148E.180, subdivision 3, and must accompany the application. A  
 326.7 licensee who is approved for emeritus active license before the license expiration date is  
 326.8 not entitled to receive a refund for any portion of the license or renewal fee.

326.9 ~~Subd. 4. **Time limits for temporary leaves.** A licensee may maintain an inactive~~  
 326.10 ~~license on temporary leave for no more than five consecutive years. If a licensee does~~  
 326.11 ~~not apply for reactivation within 60 days following the end of the consecutive five-year~~  
 326.12 ~~period, the license automatically expires.~~

326.13 ~~Subd. 5. **Time limits for emeritus license.** A licensee with an emeritus license may~~  
 326.14 ~~not apply for reactivation according to section 148E.080 after five years following the~~  
 326.15 ~~granting of the emeritus license. However, after five years following the granting of the~~  
 326.16 ~~emeritus license, an individual may apply for new licensure according to section 148E.055.~~

326.17 ~~Subd. 6. **Prohibition on practice.** (a) Except as provided in paragraph (b), a~~  
 326.18 ~~licensee whose license is inactive must not practice, attempt to practice, offer to practice,~~  
 326.19 ~~or advertise or hold out as authorized to practice social work.~~

326.20 ~~(b) The board may grant a variance to the requirements of paragraph (a) if a licensee~~  
 326.21 ~~on inactive status provides emergency social work services. A variance is granted only~~  
 326.22 ~~if the board provides the variance in writing to the licensee. The board may impose~~  
 326.23 ~~conditions or restrictions on the variance.~~

326.24 ~~Subd. 7. **Representations of professional status.** In making representations of~~  
 326.25 ~~professional status to the public, a licensee whose license is inactive must state that the~~  
 326.26 ~~license is inactive and that the licensee cannot practice social work.~~

326.27 ~~Subd. 8. **Disciplinary or other action.** The board may resolve any pending~~  
 326.28 ~~complaints against a licensee before approving an application for inactive status an~~  
 326.29 ~~alternate license specified in this section. The board may take action according to sections~~  
 326.30 ~~148E.255 to 148E.270 against a licensee whose license is inactive who is issued an~~  
 326.31 ~~alternate license specified in this section based on conduct occurring before the license is~~  
 326.32 ~~inactive or conduct occurring while the license is inactive effective.~~

326.33 Sec. 5. Minnesota Statutes 2014, section 148E.080, subdivision 1, is amended to read:

326.34 Subdivision 1. **Mailing notices to licensees on temporary leave.** The board must  
 326.35 mail a notice for reactivation to a licensee on temporary leave at least 45 days before the

327.1 expiration date of the license according to section 148E.075, subdivision ~~4~~ 1. Mailing  
 327.2 the notice by United States mail to the licensee's last known mailing address constitutes  
 327.3 valid mailing. Failure to receive the reactivation notice does not relieve a licensee of the  
 327.4 obligation to comply with the provisions of this section to reactivate a license.

327.5 Sec. 6. Minnesota Statutes 2014, section 148E.080, subdivision 2, is amended to read:

327.6 Subd. 2. **Reactivation from a temporary leave or emeritus status.** To reactivate a  
 327.7 license from a temporary leave or emeritus status, a licensee must do the following within  
 327.8 the time period specified in section 148E.075, subdivisions ~~4 and 5~~ 1, 1a, and 1b:

327.9 (1) complete an application form specified by the board;

327.10 (2) document compliance with the continuing education requirements specified in  
 327.11 subdivision 4;

327.12 (3) submit a supervision plan, if required;

327.13 (4) pay the reactivation of ~~an inactive licensee~~ a license fee specified in section  
 327.14 148E.180; and

327.15 (5) pay the wall certificate fee according to section 148E.095, subdivision 1,  
 327.16 paragraph (b) or (c), if the licensee needs a duplicate license.

327.17 Sec. 7. Minnesota Statutes 2014, section 148E.180, subdivision 2, is amended to read:

327.18 Subd. 2. **License fees.** License fees are as follows:

327.19 (1) for a licensed social worker, \$81;

327.20 (2) for a licensed graduate social worker, \$144;

327.21 (3) for a licensed independent social worker, \$216;

327.22 (4) for a licensed independent clinical social worker, \$238.50;

327.23 (5) for an emeritus inactive license, \$43.20; ~~and~~

327.24 (6) for an emeritus active license, one-half of the renewal fee specified in subdivision  
 327.25 3; and

327.26 (7) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

327.27 If the licensee's initial license term is less or more than 24 months, the required  
 327.28 license fees must be prorated proportionately.

327.29 Sec. 8. Minnesota Statutes 2014, section 148E.180, subdivision 5, is amended to read:

327.30 Subd. 5. **Late fees.** Late fees are as follows:

327.31 (1) renewal late fee, one-fourth of the renewal fee specified in subdivision 3; ~~and~~

327.32 (2) supervision plan late fee, \$40-; and

328.1 (3) license late fee, \$100 plus the prorated share of the license fee specified in  
 328.2 subdivision 2 for the number of months during which the individual practiced social  
 328.3 work without a license.

328.4 Sec. 9. Minnesota Statutes 2014, section 150A.091, subdivision 4, is amended to read:

328.5 Subd. 4. **Annual license fees.** Each limited faculty or resident dentist shall submit  
 328.6 with an annual license renewal application a fee established by the board not to exceed  
 328.7 the following amounts:

- 328.8 (1) limited faculty dentist, \$168; and
- 328.9 (2) resident dentist or dental provider, ~~\$59~~ \$85.

328.10 Sec. 10. Minnesota Statutes 2014, section 150A.091, subdivision 5, is amended to read:

328.11 Subd. 5. **Biennial license or permit fees.** Each of the following applicants shall  
 328.12 submit with a biennial license or permit renewal application a fee as established by the  
 328.13 board, not to exceed the following amounts:

- 328.14 (1) dentist or full faculty dentist, ~~\$336~~ \$475;
- 328.15 (2) dental therapist, ~~\$180~~ \$300;
- 328.16 (3) dental hygienist, ~~\$118~~ \$200;
- 328.17 (4) licensed dental assistant, ~~\$80~~ \$150; and
- 328.18 (5) dental assistant with a permit as described in Minnesota Rules, part 3100.8500,  
 328.19 subpart 3, \$24.

328.20 Sec. 11. Minnesota Statutes 2014, section 150A.091, subdivision 11, is amended to read:

328.21 Subd. 11. **Certificate application fee for anesthesia/sedation.** Each dentist  
 328.22 shall submit with a general anesthesia or moderate sedation application ~~or~~ a contracted  
 328.23 sedation provider application, or biennial renewal, a fee as established by the board not to  
 328.24 exceed the following amounts:

- 328.25 (1) for both a general anesthesia and moderate sedation application, ~~\$250~~ \$400;
- 328.26 (2) for a general anesthesia application only, ~~\$250~~ \$400;
- 328.27 (3) for a moderate sedation application only, ~~\$250~~ \$400; and
- 328.28 (4) for a contracted sedation provider application, ~~\$250~~ \$400.

328.29 Sec. 12. Minnesota Statutes 2014, section 150A.091, is amended by adding a  
 328.30 subdivision to read:



329.1 Subd. 17. **Advanced dental therapy examination fee.** Any dental therapist eligible  
 329.2 to sit for the advanced dental therapy certification examination must submit with the  
 329.3 application a fee as established by the board, not to exceed \$250.

329.4 Sec. 13. Minnesota Statutes 2014, section 150A.091, is amended by adding a  
 329.5 subdivision to read:

329.6 Subd. 18. **Corporation or professional firm late fee.** Any corporation or  
 329.7 professional firm whose annual fee is not postmarked or otherwise received by the board  
 329.8 by the due date of December 31 shall, in addition to the fee, submit a late fee as established  
 329.9 by the board, not to exceed \$15.

329.10 Sec. 14. Minnesota Statutes 2014, section 150A.31, is amended to read:

329.11 **150A.31 FEES.**

329.12 (a) The initial biennial registration fee is \$50.

329.13 (b) The biennial renewal registration fee is ~~\$25~~ not to exceed \$80.

329.14 (c) The fees specified in this section are nonrefundable and shall be deposited in  
 329.15 the state government special revenue fund.

329.16 Sec. 15. Minnesota Statutes 2014, section 151.065, subdivision 1, is amended to read:

329.17 Subdivision 1. **Application fees.** Application fees for licensure and registration  
 329.18 are as follows:

329.19 (1) pharmacist licensed by examination, ~~\$130~~ \$145;

329.20 (2) pharmacist licensed by reciprocity, ~~\$225~~ \$240;

329.21 (3) pharmacy intern, ~~\$30~~ \$37.50;

329.22 (4) pharmacy technician, ~~\$30~~ \$37.50;

329.23 (5) pharmacy, ~~\$190~~ \$225;

329.24 (6) drug wholesaler, legend drugs only, ~~\$200~~ \$235;

329.25 (7) drug wholesaler, legend and nonlegend drugs, ~~\$200~~ \$235;

329.26 (8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~\$175~~ \$210;

329.27 (9) drug wholesaler, medical gases, ~~\$150~~ \$175;

329.28 (10) drug wholesaler, also licensed as a pharmacy in Minnesota, ~~\$125~~ \$150;

329.29 (11) drug manufacturer, legend drugs only, ~~\$200~~ \$235;

329.30 (12) drug manufacturer, legend and nonlegend drugs, ~~\$200~~ \$235;

329.31 (13) drug manufacturer, nonlegend or veterinary legend drugs, ~~\$175~~ \$210;

329.32 (14) drug manufacturer, medical gases, ~~\$150~~ \$185;

329.33 (15) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~\$125~~ \$150;

- 330.1 (16) medical gas distributor, ~~\$75~~ \$110;
- 330.2 (17) controlled substance researcher, ~~\$50~~ \$75; and
- 330.3 (18) pharmacy professional corporation, ~~\$100~~ \$125.

330.4 Sec. 16. Minnesota Statutes 2014, section 151.065, subdivision 2, is amended to read:

330.5 Subd. 2. **Original license fee.** The pharmacist original licensure fee, ~~\$130~~ \$145.

330.6 Sec. 17. Minnesota Statutes 2014, section 151.065, subdivision 3, is amended to read:

330.7 Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees  
330.8 are as follows:

- 330.9 (1) pharmacist, ~~\$130~~ \$145;
- 330.10 (2) pharmacy technician, ~~\$30~~ \$37.50;
- 330.11 (3) pharmacy, ~~\$190~~ \$225;
- 330.12 (4) drug wholesaler, legend drugs only, ~~\$200~~ \$235;
- 330.13 (5) drug wholesaler, legend and nonlegend drugs, ~~\$200~~ \$235;
- 330.14 (6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~\$175~~ \$210;
- 330.15 (7) drug wholesaler, medical gases, ~~\$150~~ \$185;
- 330.16 (8) drug wholesaler, also licensed as a pharmacy in Minnesota, ~~\$125~~ \$150;
- 330.17 (9) drug manufacturer, legend drugs only, ~~\$200~~ \$235;
- 330.18 (10) drug manufacturer, legend and nonlegend drugs, ~~\$200~~ \$235;
- 330.19 (11) drug manufacturer, nonlegend, veterinary legend drugs, or both, ~~\$175~~ \$210;
- 330.20 (12) drug manufacturer, medical gases, ~~\$150~~ \$185;
- 330.21 (13) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~\$125~~ \$150;
- 330.22 (14) medical gas distributor, ~~\$75~~ \$110;
- 330.23 (15) controlled substance researcher, ~~\$50~~ \$75; and
- 330.24 (16) pharmacy professional corporation, ~~\$45~~ \$75.

330.25 Sec. 18. Minnesota Statutes 2014, section 151.065, subdivision 4, is amended to read:

330.26 Subd. 4. **Miscellaneous fees.** Fees for issuance of affidavits and duplicate licenses  
330.27 and certificates are as follows:

- 330.28 (1) intern affidavit, ~~\$15~~ \$20;
- 330.29 (2) duplicate small license, ~~\$15~~ \$20; and
- 330.30 (3) duplicate large certificate, ~~\$25~~ \$30.

330.31 Sec. 19. **REPEALER.**

330.32 Minnesota Statutes 2014, section 148E.060, subdivision 12, is repealed.

331.1 **ARTICLE 10**

331.2 **HEALTH CARE**

331.3 Section 1. Minnesota Statutes 2014, section 16A.724, subdivision 2, is amended to read:

331.4 Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available  
 331.5 resources in the health care access fund exceed expenditures in that fund, effective for  
 331.6 the biennium beginning July 1, 2007, the commissioner of management and budget shall  
 331.7 transfer the excess funds from the health care access fund to the general fund on June 30  
 331.8 of each year, provided that the amount transferred in any fiscal biennium shall not exceed  
 331.9 \$96,000,000. The purpose of this transfer is to meet the rate increase required under Laws  
 331.10 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6.

331.11 (b) ~~For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and,~~  
 331.12 ~~if necessary,~~ The commissioner shall reduce these transfers from the health care access  
 331.13 fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary,  
 331.14 transfer sufficient funds from the general fund to the health care access fund to meet  
 331.15 annual MinnesotaCare expenditures.

331.16 (c) Notwithstanding section 295.581, to the extent available resources in the health  
 331.17 care access fund exceed expenditures in that fund after the transfer required in paragraph  
 331.18 (a), effective for the biennium beginning July 1, 2013, the commissioner of management  
 331.19 and budget shall transfer \$1,000,000 each fiscal year from the health access fund to  
 331.20 the medical education and research costs fund established under section 62J.692, for  
 331.21 distribution under section 62J.692, subdivision 4, paragraph (c).

331.22 Sec. 2. Minnesota Statutes 2014, section 62A.045, is amended to read:

331.23 **62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT**  
 331.24 **HEALTH PROGRAMS.**

331.25 (a) As a condition of doing business in Minnesota or providing coverage to  
 331.26 residents of Minnesota covered by this section, each health insurer shall comply with the  
 331.27 requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171, including  
 331.28 any federal regulations adopted under that act, to the extent that it imposes a requirement  
 331.29 that applies in this state and that is not also required by the laws of this state. This section  
 331.30 does not require compliance with any provision of the federal act prior to the effective date  
 331.31 provided for that provision in the federal act. The commissioner shall enforce this section.

331.32 For the purpose of this section, "health insurer" includes self-insured plans, group  
 331.33 health plans (as defined in section 607(1) of the Employee Retirement Income Security  
 331.34 Act of 1974), service benefit plans, managed care organizations, pharmacy benefit

332.1 managers, or other parties that are by contract legally responsible to pay a claim for a  
332.2 health-care item or service for an individual receiving benefits under paragraph (b).

332.3 (b) No plan offered by a health insurer issued or renewed to provide coverage to  
332.4 a Minnesota resident shall contain any provision denying or reducing benefits because  
332.5 services are rendered to a person who is eligible for or receiving medical benefits pursuant  
332.6 to title XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256;  
332.7 256B; or 256D or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331,  
332.8 subdivision 2; 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer  
332.9 providing benefits under plans covered by this section shall use eligibility for medical  
332.10 programs named in this section as an underwriting guideline or reason for nonacceptance  
332.11 of the risk.

332.12 (c) If payment for covered expenses has been made under state medical programs for  
332.13 health care items or services provided to an individual, and a third party has a legal liability  
332.14 to make payments, the rights of payment and appeal of an adverse coverage decision for the  
332.15 individual, or in the case of a child their responsible relative or caretaker, will be subrogated  
332.16 to the state agency. The state agency may assert its rights under this section within three  
332.17 years of the date the service was rendered. For purposes of this section, "state agency"  
332.18 includes prepaid health plans under contract with the commissioner according to sections  
332.19 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12; children's mental health  
332.20 collaboratives under section 245.493; demonstration projects for persons with disabilities  
332.21 under section 256B.77; nursing homes under the alternative payment demonstration project  
332.22 under section 256B.434; and county-based purchasing entities under section 256B.692.

332.23 (d) Notwithstanding any law to the contrary, when a person covered by a plan  
332.24 offered by a health insurer receives medical benefits according to any statute listed in this  
332.25 section, payment for covered services or notice of denial for services billed by the provider  
332.26 must be issued directly to the provider. If a person was receiving medical benefits through  
332.27 the Department of Human Services at the time a service was provided, the provider must  
332.28 indicate this benefit coverage on any claim forms submitted by the provider to the health  
332.29 insurer for those services. If the commissioner of human services notifies the health  
332.30 insurer that the commissioner has made payments to the provider, payment for benefits or  
332.31 notices of denials issued by the health insurer must be issued directly to the commissioner.  
332.32 Submission by the department to the health insurer of the claim on a Department of  
332.33 Human Services claim form is proper notice and shall be considered proof of payment of  
332.34 the claim to the provider and supersedes any contract requirements of the health insurer  
332.35 relating to the form of submission. Liability to the insured for coverage is satisfied to the

333.1 extent that payments for those benefits are made by the health insurer to the provider or  
333.2 the commissioner as required by this section.

333.3 (e) When a state agency has acquired the rights of an individual eligible for medical  
333.4 programs named in this section and has health benefits coverage through a health insurer,  
333.5 the health insurer shall not impose requirements that are different from requirements  
333.6 applicable to an agent or assignee of any other individual covered.

333.7 (f) A health insurer must process a clean claim made by a state agency for covered  
333.8 expenses paid under state medical programs within 90 business days of the claim's  
333.9 submission. A health insurer must process all other claims made by a state agency for  
333.10 covered expenses paid under a state medical program within the timeline set forth in Code  
333.11 of Federal Regulations, title 42, section 447.45(d)(4).

333.12 (g) A health insurer may request a refund of a claim paid in error to the Department  
333.13 of Human Services within two years of the date the payment was made to the department.  
333.14 A request for a refund shall not be honored by the department if the health insurer makes  
333.15 the request after the time period has lapsed.

333.16 Sec. 3. Minnesota Statutes 2014, section 174.29, subdivision 1, is amended to read:

333.17 Subdivision 1. **Definition.** For the purpose of sections 174.29 and 174.30 "special  
333.18 transportation service" means motor vehicle transportation provided on a regular basis  
333.19 by a public or private entity or person that is designed exclusively or primarily to serve  
333.20 individuals who are elderly or disabled and who are unable to use regular means of  
333.21 transportation but do not require ambulance service, as defined in section 144E.001,  
333.22 subdivision 3. Special transportation service includes but is not limited to service provided  
333.23 by specially equipped buses, vans, taxis, and volunteers driving private automobiles.  
333.24 Special transportation service also means those nonemergency medical transportation  
333.25 services under section 256B.0625, subdivision 17, that are subject to the operating  
333.26 standards for special transportation service under sections 174.29 to 174.30 and Minnesota  
333.27 Rules, chapter 8840.

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

333.29 Sec. 4. Minnesota Statutes 2014, section 174.30, subdivision 3, is amended to read:

333.30 Subd. 3. **Other standards; wheelchair securement; protected transport.** (a) A  
333.31 special transportation service that transports individuals occupying wheelchairs is subject  
333.32 to the provisions of sections 299A.11 to 299A.18 concerning wheelchair securement  
333.33 devices. The commissioners of transportation and public safety shall cooperate in the  
333.34 enforcement of this section and sections 299A.11 to 299A.18 so that a single inspection

334.1 is sufficient to ascertain compliance with sections 299A.11 to 299A.18 and with the  
334.2 standards adopted under this section. Representatives of the Department of Transportation  
334.3 may inspect wheelchair securement devices in vehicles operated by special transportation  
334.4 service providers to determine compliance with sections 299A.11 to 299A.18 and to issue  
334.5 certificates under section 299A.14, subdivision 4.

334.6 (b) In place of a certificate issued under section 299A.14, the commissioner may  
334.7 issue a decal under subdivision 4 for a vehicle equipped with a wheelchair securement  
334.8 device if the device complies with sections 299A.11 to 299A.18 and the decal displays the  
334.9 information in section 299A.14, subdivision 4.

334.10 (c) For vehicles designated as protected transport under section 256B.0625,  
334.11 subdivision 17, paragraph (h), the commissioner of transportation, during the  
334.12 commissioner's inspection, shall check to ensure the safety provisions contained in that  
334.13 paragraph are in working order.

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

334.15 Sec. 5. Minnesota Statutes 2014, section 174.30, subdivision 4, is amended to read:

334.16 Subd. 4. **Vehicle and equipment inspection; rules; decal; complaint contact**  
334.17 **information; restrictions on name of service.** (a) The commissioner shall inspect or  
334.18 provide for the inspection of vehicles at least annually. In addition to scheduled annual  
334.19 inspections and reinspections scheduled for the purpose of verifying that deficiencies have  
334.20 been corrected, unannounced inspections of any vehicle may be conducted.

334.21 (b) On determining that a vehicle or vehicle equipment is in a condition that is likely  
334.22 to cause an accident or breakdown, the commissioner shall require the vehicle to be taken  
334.23 out of service immediately. The commissioner shall require that vehicles and equipment  
334.24 not meeting standards be repaired and brought into conformance with the standards  
334.25 and shall require written evidence of compliance from the operator before allowing the  
334.26 operator to return the vehicle to service.

334.27 (c) The commissioner shall provide in the rules procedures for inspecting vehicles,  
334.28 removing unsafe vehicles from service, determining and requiring compliance, and  
334.29 reviewing driver qualifications.

334.30 (d) The commissioner shall design a distinctive decal to be issued to special  
334.31 transportation service providers with a current certificate of compliance under this section.  
334.32 A decal is valid for one year from the last day of the month in which it is issued. A person  
334.33 who is subject to the operating standards adopted under this section may not provide  
334.34 special transportation service in a vehicle that does not conspicuously display a decal  
334.35 issued by the commissioner.

335.1 (e) All special transportation service providers shall pay an annual fee of \$45  
 335.2 to obtain a decal. Providers of ambulance service, as defined in section 144E.001,  
 335.3 subdivision 3, are exempt from the annual fee. Fees collected under this paragraph must  
 335.4 be deposited in the trunk highway fund, and are appropriated to the commissioner to pay  
 335.5 for costs related to administering the special transportation service program.

335.6 (f) Special transportation service providers shall prominently display in each vehicle  
 335.7 all contact information for the submission of complaints regarding the transportation  
 335.8 services provided to that individual. All vehicles providing service under section  
 335.9 473.386 shall display contact information for the Metropolitan Council. All other special  
 335.10 transportation service vehicles shall display contact information for the commissioner of  
 335.11 transportation.

335.12 (g) Nonemergency medical transportation providers must comply with Minnesota  
 335.13 Rules, part 8840.5450, except that a provider may use the phrase "nonemergency medical  
 335.14 transportation" in its name or in advertisements or information describing the service.

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

335.16 Sec. 6. Minnesota Statutes 2014, section 174.30, is amended by adding a subdivision  
 335.17 to read:

335.18 Subd. 4b. **Variance from the standards.** A nonemergency medical transportation  
 335.19 provider who was not subject to the standards in this section prior to July 1, 2014, must  
 335.20 apply for a variance from the commissioner if the provider cannot meet the standards  
 335.21 by January 1, 2017. The commissioner may grant or deny the variance application.  
 335.22 Variances, if granted, shall not exceed 60 days unless extended by the commissioner.

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

335.24 Sec. 7. Minnesota Statutes 2014, section 174.30, is amended by adding a subdivision  
 335.25 to read:

335.26 Subd. 10. **Background studies.** (a) Providers of special transportation service  
 335.27 regulated under this section must initiate background studies in accordance with chapter  
 335.28 245C on the following individuals:

335.29 (1) each person with a direct or indirect ownership interest of five percent or higher  
 335.30 in the transportation service provider;

335.31 (2) each controlling individual as defined under section 245A.02;

335.32 (3) managerial officials as defined in section 245A.02;

335.33 (4) each driver employed by the transportation service provider;

336.1 (5) each individual employed by the transportation service provider to assist a  
336.2 passenger during transport; and

336.3 (6) all employees of the transportation service agency who provide administrative  
336.4 support, including those who:

336.5 (i) may have face-to-face contact with or access to passengers, their personal  
336.6 property, or their private data;

336.7 (ii) perform any scheduling or dispatching tasks; or

336.8 (iii) perform any billing activities.

336.9 (b) The transportation service provider must initiate the background studies required  
336.10 under paragraph (a) using the online NETStudy system operated by the commissioner  
336.11 of human services.

336.12 (c) The transportation service provider shall not permit any individual to provide  
336.13 any service listed in paragraph (a) until the transportation service provider has received  
336.14 notification from the commissioner of human services indicating that the individual:

336.15 (1) is not disqualified under chapter 245C; or

336.16 (2) is disqualified, but has received a set-aside of that disqualification according to  
336.17 section 245C.23 related to that transportation service provider.

336.18 (d) When a local or contracted agency is authorizing a ride under section 256B.0625,  
336.19 subdivision 17, by a volunteer driver, and the agency authorizing the ride has reason  
336.20 to believe the volunteer driver has a history that would disqualify the individual or  
336.21 that may pose a risk to the health or safety of passengers, the agency may initiate a  
336.22 background study to be completed according to chapter 245C using the commissioner  
336.23 of human services' online NETStudy system, or through contacting the Department of  
336.24 Human Services background study division for assistance. The agency that initiates the  
336.25 background study under this paragraph shall be responsible for providing the volunteer  
336.26 driver with the privacy notice required under section 245C.05, subdivision 2c, and  
336.27 payment for the background study required under section 245C.10, subdivision 11, before  
336.28 the background study is completed.

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

336.30 Sec. 8. Minnesota Statutes 2014, section 245C.03, is amended by adding a subdivision  
336.31 to read:

336.32 **Subd. 10. Providers of special transportation service.** The commissioner shall  
336.33 conduct background studies on any individual required under section 174.30 to have a  
336.34 background study completed under this chapter.



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

337.2 Sec. 9. Minnesota Statutes 2014, section 245C.10, is amended by adding a subdivision  
337.3 to read:

337.4 **Subd. 11. Providers of special transportation service.** The commissioner shall  
337.5 recover the cost of background studies initiated by providers of special transportation  
337.6 service under section 174.30 through a fee of no more than \$20 per study. The fees  
337.7 collected under this subdivision are appropriated to the commissioner for the purpose of  
337.8 conducting background studies.

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

337.10 Sec. 10. Minnesota Statutes 2014, section 256.015, subdivision 7, is amended to read:

337.11 **Subd. 7. Cooperation with information requests required.** (a) Upon the request  
337.12 of the commissioner of human services:

337.13 (1) any state agency or third-party payer shall cooperate by furnishing information to  
337.14 help establish a third-party liability, as required by the federal Deficit Reduction Act of  
337.15 2005, Public Law 109-171;

337.16 (2) any employer or third-party payer shall cooperate by furnishing a data file  
337.17 containing information about group health insurance plan or medical benefit plan coverage  
337.18 of its employees or insureds within 60 days of the request. The information in the data file  
337.19 must include at least the following: full name, date of birth, Social Security number if  
337.20 collected and stored in a system routinely used for producing data files by the employer  
337.21 or third-party payer, employer name, policy identification number, group identification  
337.22 number, and plan or coverage type.

337.23 (b) For purposes of section 176.191, subdivision 4, the commissioner of labor and  
337.24 industry may allow the commissioner of human services and county agencies direct access  
337.25 and data matching on information relating to workers' compensation claims in order to  
337.26 determine whether the claimant has reported the fact of a pending claim and the amount  
337.27 paid to or on behalf of the claimant to the commissioner of human services.

337.28 (c) For the purpose of compliance with section 169.09, subdivision 13, and  
337.29 federal requirements under Code of Federal Regulations, title 42, section 433.138

337.30 (d)(4), the commissioner of public safety shall provide accident data as requested by  
337.31 the commissioner of human services. The disclosure shall not violate section 169.09,  
337.32 subdivision 13, paragraph (d).

337.33 (d) The commissioner of human services and county agencies shall limit its use of  
337.34 information gained from agencies, third-party payers, and employers to purposes directly

338.1 connected with the administration of its public assistance and child support programs. The  
338.2 provision of information by agencies, third-party payers, and employers to the department  
338.3 under this subdivision is not a violation of any right of confidentiality or data privacy.

338.4 Sec. 11. Minnesota Statutes 2014, section 256.969, subdivision 1, is amended to read:

338.5 Subdivision 1. **Hospital cost index.** (a) The hospital cost index shall be the change  
338.6 in the Consumer Price Index-All Items (United States city average) (CPI-U) forecasted  
338.7 by Data Resources, Inc. The commissioner shall use the indices as forecasted in the  
338.8 third quarter of the calendar year prior to the rate year. The hospital cost index may be  
338.9 used to adjust the base year operating payment rate through the rate year on an annually  
338.10 compounded basis.

338.11 (b) For fiscal years beginning on or after July 1, 1993, the commissioner of human  
338.12 services shall not provide automatic annual inflation adjustments for hospital payment  
338.13 rates under medical assistance. ~~The commissioner of management and budget shall~~  
338.14 ~~include as a budget change request in each biennial detailed expenditure budget submitted~~  
338.15 ~~to the legislature under section 16A.11 annual adjustments in hospital payment rates under~~  
338.16 ~~medical assistance based upon the hospital cost index.~~

338.17 Sec. 12. Minnesota Statutes 2014, section 256.969, subdivision 2b, is amended to read:

338.18 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after  
338.19 November 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be  
338.20 paid according to the following:

338.21 (1) critical access hospitals as defined by Medicare shall be paid using a cost-based  
338.22 methodology;

338.23 (2) long-term hospitals as defined by Medicare shall be paid on a per diem  
338.24 methodology under subdivision 25;

338.25 (3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation  
338.26 distinct parts as defined by Medicare shall be paid according to the methodology under  
338.27 subdivision 12; and

338.28 (4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

338.29 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall  
338.30 not be rebased, except that a Minnesota long-term hospital shall be rebased effective  
338.31 January 1, 2011, based on its most recent Medicare cost report ending on or before  
338.32 September 1, 2008, with the provisions under subdivisions 9 and 23, based on the rates  
338.33 in effect on December 31, 2010. For rate setting periods after November 1, 2014, in

339.1 which the base years are updated, a Minnesota long-term hospital's base year shall remain  
339.2 within the same period as other hospitals.

339.3 (c) Effective for discharges occurring on and after November 1, 2014, payment rates  
339.4 for hospital inpatient services provided by hospitals located in Minnesota or the local trade  
339.5 area, except for the hospitals paid under the methodologies described in paragraph (a),  
339.6 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a  
339.7 manner similar to Medicare. The base year for the rates effective November 1, 2014, shall  
339.8 be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring  
339.9 that the total aggregate payments under the rebased system are equal to the total aggregate  
339.10 payments that were made for the same number and types of services in the base year.  
339.11 Separate budget neutrality calculations shall be determined for payments made to critical  
339.12 access hospitals and payments made to hospitals paid under the DRG system. Only the rate  
339.13 increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased  
339.14 during the entire base period shall be incorporated into the budget neutrality calculation.

339.15 (d) For discharges occurring on or after November 1, 2014, through ~~June 30, 2016~~  
339.16 the next rebasing that occurs, the rebased rates under paragraph (c) that apply to hospitals  
339.17 under paragraph (a), clause (4), shall include adjustments to the projected rates that result  
339.18 in no greater than a five percent increase or decrease from the base year payments for any  
339.19 hospital. Any adjustments to the rates made by the commissioner under this paragraph and  
339.20 paragraph (e) shall maintain budget neutrality as described in paragraph (c).

339.21 (e) For discharges occurring on or after November 1, 2014, through ~~June 30, 2016~~,  
339.22 the next rebasing that occurs the commissioner may make additional adjustments to the  
339.23 rebased rates, and when evaluating whether additional adjustments should be made, the  
339.24 commissioner shall consider the impact of the rates on the following:

- 339.25 (1) pediatric services;
- 339.26 (2) behavioral health services;
- 339.27 (3) trauma services as defined by the National Uniform Billing Committee;
- 339.28 (4) transplant services;
- 339.29 (5) obstetric services, newborn services, and behavioral health services provided  
339.30 by hospitals outside the seven-county metropolitan area;
- 339.31 (6) outlier admissions;
- 339.32 (7) low-volume providers; and
- 339.33 (8) services provided by small rural hospitals that are not critical access hospitals.

339.34 (f) Hospital payment rates established under paragraph (c) must incorporate the  
339.35 following:

340.1 (1) for hospitals paid under the DRG methodology, the base year payment rate per  
340.2 admission is standardized by the applicable Medicare wage index and adjusted by the  
340.3 hospital's disproportionate population adjustment;

340.4 (2) for critical access hospitals, interim per diem payment rates shall be based on the  
340.5 ratio of cost and charges reported on the base year Medicare cost report or reports and  
340.6 applied to medical assistance utilization data. Final settlement payments for a state fiscal  
340.7 year must be determined based on a review of the medical assistance cost report required  
340.8 under subdivision 4b for the applicable state fiscal year;

340.9 (3) the cost and charge data used to establish hospital payment rates must only  
340.10 reflect inpatient services covered by medical assistance; and

340.11 (4) in determining hospital payment rates for discharges occurring on or after the  
340.12 rate year beginning January 1, 2011, through December 31, 2012, the hospital payment  
340.13 rate per discharge shall be based on the cost-finding methods and allowable costs of the  
340.14 Medicare program in effect during the base year or years.

340.15 (g) The commissioner shall validate the rates effective November 1, 2014, by  
340.16 applying the rates established under paragraph (c), and any adjustments made to the rates  
340.17 under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine  
340.18 whether the total aggregate payments for the same number and types of services under the  
340.19 rebased rates are equal to the total aggregate payments made during calendar year 2013.

340.20 (h) Effective for discharges occurring on or after July 1, 2017, and every two  
340.21 years thereafter, payment rates under this section shall be rebased to reflect only those  
340.22 changes in hospital costs between the existing base year and the next base year. The  
340.23 commissioner shall establish the base year for each rebasing period considering the most  
340.24 recent year for which filed Medicare cost reports are available. The estimated change in  
340.25 the average payment per hospital discharge resulting from a scheduled rebasing must be  
340.26 calculated and made available to the legislature by January 15 of each year in which  
340.27 rebasing is scheduled to occur, and must include by hospital the differential in payment  
340.28 rates compared to the individual hospital's costs.

340.29 (i) Effective for discharges occurring on or after July 1, 2015, payment rates for  
340.30 critical access hospitals located in Minnesota or the local trade area shall be determined  
340.31 using a new cost-based methodology. The commissioner shall establish within the  
340.32 methodology tiers of payment designed to promote efficiency and cost-effectiveness.  
340.33 Annual payments to hospitals under this paragraph shall equal the total cost for critical  
340.34 access hospitals as reflected in base year cost reports, and until the next rebasing that  
340.35 occurs, shall result in no greater than a five percent decrease from the base year payments  
340.36 for any hospital. The new cost-based rate shall be the final rate and shall not be settled to

341.1 actual incurred costs. The factors used to develop the new methodology may include but  
 341.2 are not limited to:

341.3 (1) the ratio between the hospital's costs for treating medical assistance patients and  
 341.4 the hospital's charges to the medical assistance program;

341.5 (2) the ratio between the hospital's costs for treating medical assistance patients and  
 341.6 the hospital's payments received from the medical assistance program for the care of  
 341.7 medical assistance patients;

341.8 (3) the ratio between the hospital's charges to the medical assistance program and  
 341.9 the hospital's payments received from the medical assistance program for the care of  
 341.10 medical assistance patients;

341.11 (4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

341.12 (5) the proportion of that hospital's costs that are administrative and trends in  
 341.13 administrative costs; and

341.14 (6) geographic location.

341.15 Sec. 13. Minnesota Statutes 2014, section 256.969, subdivision 3a, is amended to read:

341.16 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance  
 341.17 program must not be submitted until the recipient is discharged. However, the  
 341.18 commissioner shall establish monthly interim payments for inpatient hospitals that have  
 341.19 individual patient lengths of stay over 30 days regardless of diagnostic category. Except  
 341.20 as provided in section 256.9693, medical assistance reimbursement for treatment of  
 341.21 mental illness shall be reimbursed based on diagnostic classifications. Individual hospital  
 341.22 payments established under this section and sections 256.9685, 256.9686, and 256.9695, in  
 341.23 addition to third-party and recipient liability, for discharges occurring during the rate year  
 341.24 shall not exceed, in aggregate, the charges for the medical assistance covered inpatient  
 341.25 services paid for the same period of time to the hospital. Services that have rates established  
 341.26 under subdivision 11 or 12, must be limited separately from other services. After  
 341.27 consulting with the affected hospitals, the commissioner may consider related hospitals  
 341.28 one entity and may merge the payment rates while maintaining separate provider numbers.  
 341.29 The operating and property base rates per admission or per day shall be derived from the  
 341.30 best Medicare and claims data available when rates are established. The commissioner  
 341.31 shall determine the best Medicare and claims data, taking into consideration variables of  
 341.32 recency of the data, audit disposition, settlement status, and the ability to set rates in a  
 341.33 timely manner. The commissioner shall notify hospitals of payment rates 30 days prior to  
 341.34 implementation. The rate setting data must reflect the admissions data used to establish  
 341.35 relative values. The commissioner may adjust base year cost, relative value, and case mix

342.1 index data to exclude the costs of services that have been discontinued by the October  
342.2 1 of the year preceding the rate year or that are paid separately from inpatient services.  
342.3 Inpatient stays that encompass portions of two or more rate years shall have payments  
342.4 established based on payment rates in effect at the time of admission unless the date of  
342.5 admission preceded the rate year in effect by six months or more. In this case, operating  
342.6 payment rates for services rendered during the rate year in effect and established based on  
342.7 the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

342.8 (b) For fee-for-service admissions occurring on or after July 1, 2002, the total  
342.9 payment, before third-party liability and spenddown, made to hospitals for inpatient  
342.10 services is reduced by .5 percent from the current statutory rates.

342.11 (c) In addition to the reduction in paragraph (b), the total payment for fee-for-service  
342.12 admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before  
342.13 third-party liability and spenddown, is reduced five percent from the current statutory  
342.14 rates. Mental health services within diagnosis related groups 424 to 432 or corresponding  
342.15 APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph.

342.16 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for  
342.17 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for  
342.18 inpatient services before third-party liability and spenddown, is reduced 6.0 percent from  
342.19 the current statutory rates. Mental health services within diagnosis related groups 424  
342.20 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are  
342.21 excluded from this paragraph. Payments made to managed care plans shall be reduced for  
342.22 services provided on or after January 1, 2006, to reflect this reduction.

342.23 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for  
342.24 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made  
342.25 to hospitals for inpatient services before third-party liability and spenddown, is reduced  
342.26 3.46 percent from the current statutory rates. Mental health services with diagnosis  
342.27 related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under  
342.28 subdivision 16 are excluded from this paragraph. Payments made to managed care plans  
342.29 shall be reduced for services provided on or after January 1, 2009, through June 30, 2009,  
342.30 to reflect this reduction.

342.31 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment  
342.32 for fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011,  
342.33 made to hospitals for inpatient services before third-party liability and spenddown, is  
342.34 reduced 1.9 percent from the current statutory rates. Mental health services with diagnosis  
342.35 related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under  
342.36 subdivision 16 are excluded from this paragraph. Payments made to managed care plans

343.1 shall be reduced for services provided on or after July 1, 2009, through June 30, 2011,  
343.2 to reflect this reduction.

343.3 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment  
343.4 for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for  
343.5 inpatient services before third-party liability and spenddown, is reduced 1.79 percent from  
343.6 the current statutory rates. Mental health services with diagnosis related groups 424 to 432  
343.7 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded  
343.8 from this paragraph. Payments made to managed care plans shall be reduced for services  
343.9 provided on or after July 1, 2011, to reflect this reduction.

343.10 (h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total  
343.11 payment for fee-for-service admissions occurring on or after July 1, 2009, made to  
343.12 hospitals for inpatient services before third-party liability and spenddown, is reduced  
343.13 one percent from the current statutory rates. Facilities defined under subdivision 16 are  
343.14 excluded from this paragraph. Payments made to managed care plans shall be reduced for  
343.15 services provided on or after October 1, 2009, to reflect this reduction.

343.16 (i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total  
343.17 payment for fee-for-service admissions occurring on or after July 1, 2011, made to  
343.18 hospitals for inpatient services before third-party liability and spenddown, is reduced  
343.19 1.96 percent from the current statutory rates. Facilities defined under subdivision 16 are  
343.20 excluded from this paragraph. Payments made to managed care plans shall be reduced for  
343.21 services provided on or after January 1, 2011, to reflect this reduction.

343.22 (j) Effective for discharges on and after November 1, 2014, from hospitals paid  
343.23 under subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this  
343.24 subdivision must be incorporated into the rebased rates established under subdivision 2b,  
343.25 paragraph (c), and must not be applied to each claim.

343.26 (k) Effective for discharges on and after July 1, 2015, from hospitals paid under  
343.27 subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision  
343.28 must be incorporated into the rates and must not be applied to each claim.

343.29 Sec. 14. Minnesota Statutes 2014, section 256.969, subdivision 3c, is amended to read:

343.30 Subd. 3c. **Rateable reduction and readmissions reduction.** (a) The total payment  
343.31 for fee for service admissions occurring on or after September 1, 2011, to October 31,  
343.32 2014, made to hospitals for inpatient services before third-party liability and spenddown,  
343.33 is reduced ten percent from the current statutory rates. Facilities defined under subdivision  
343.34 16, long-term hospitals as determined under the Medicare program, children's hospitals

344.1 whose inpatients are predominantly under 18 years of age, and payments under managed  
344.2 care are excluded from this paragraph.

344.3 (b) Effective for admissions occurring during calendar year 2010 and each year  
344.4 after, the commissioner shall calculate a readmission rate for admissions to all hospitals  
344.5 occurring within 30 days of a previous discharge using data from the Reducing Avoidable  
344.6 Readmissions Effectively (RARE) campaign. The commissioner may adjust the  
344.7 readmission rate taking into account factors such as the medical relationship, complicating  
344.8 conditions, and sequencing of treatment between the initial admission and subsequent  
344.9 readmissions.

344.10 (c) Effective for payments to all hospitals on or after July 1, 2013, through October  
344.11 31, 2014, the reduction in paragraph (a) is reduced one percentage point for every  
344.12 percentage point reduction in the overall readmissions rate between the two previous  
344.13 calendar years to a maximum of five percent.

344.14 (d) The exclusion from the rate reduction in paragraph (a) shall apply to a hospital  
344.15 located in Hennepin County with a licensed capacity of 1,700 beds as of September 1,  
344.16 2011, for admissions of children under 18 years of age occurring on or after September 1,  
344.17 2011, through August 31, 2013, but shall not apply to payments for admissions occurring  
344.18 on or after September 1, 2013, through October 31, 2014.

344.19 (e) Effective for discharges on or after November 1, 2014, from hospitals paid under  
344.20 subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this subdivision  
344.21 must be incorporated into the rebased rates established under subdivision 2b, paragraph  
344.22 (c), and must not be applied to each claim.

344.23 (f) Effective for discharges on and after July 1, 2015, from hospitals paid under  
344.24 subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision  
344.25 must be incorporated into the rates and must not be applied to each claim.

344.26 Sec. 15. Minnesota Statutes 2014, section 256.969, subdivision 9, is amended to read:

344.27 Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For  
344.28 admissions occurring on or after July 1, 1993, the medical assistance disproportionate  
344.29 population adjustment shall comply with federal law and shall be paid to a hospital,  
344.30 excluding regional treatment centers and facilities of the federal Indian Health Service,  
344.31 with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The  
344.32 adjustment must be determined as follows:

344.33 (1) for a hospital with a medical assistance inpatient utilization rate above the  
344.34 arithmetic mean for all hospitals excluding regional treatment centers and facilities of the  
344.35 federal Indian Health Service but less than or equal to one standard deviation above the



345.1 mean, the adjustment must be determined by multiplying the total of the operating and  
345.2 property payment rates by the difference between the hospital's actual medical assistance  
345.3 inpatient utilization rate and the arithmetic mean for all hospitals excluding regional  
345.4 treatment centers and facilities of the federal Indian Health Service; and

345.5 (2) for a hospital with a medical assistance inpatient utilization rate above one  
345.6 standard deviation above the mean, the adjustment must be determined by multiplying  
345.7 the adjustment that would be determined under clause (1) for that hospital by 1.1.

345.8 ~~The commissioner may establish a separate disproportionate population payment rate~~  
345.9 ~~adjustment for critical access hospitals.~~ The commissioner shall report annually on the  
345.10 number of hospitals likely to receive the adjustment authorized by this paragraph. The  
345.11 commissioner shall specifically report on the adjustments received by public hospitals and  
345.12 public hospital corporations located in cities of the first class.

345.13 (b) Certified public expenditures made by Hennepin County Medical Center shall  
345.14 be considered Medicaid disproportionate share hospital payments. Hennepin County  
345.15 and Hennepin County Medical Center shall report by June 15, 2007, on payments made  
345.16 beginning July 1, 2005, or another date specified by the commissioner, that may qualify  
345.17 for reimbursement under federal law. Based on these reports, the commissioner shall  
345.18 apply for federal matching funds.

345.19 (c) Upon federal approval of the related state plan amendment, paragraph (b) is  
345.20 effective retroactively from July 1, 2005, or the earliest effective date approved by the  
345.21 Centers for Medicare and Medicaid Services.

345.22 (d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall  
345.23 be paid in accordance with a new methodology. Annual DSH payments made under  
345.24 this paragraph shall equal the total amount of DSH payments made for 2012. The new  
345.25 methodology shall take into account a variety of factors, including but not limited to:

345.26 (1) the medical assistance utilization rate of the hospitals that receive payments  
345.27 under this subdivision;

345.28 (2) whether the hospital is located within Minnesota;

345.29 (3) the hospital's status as a safety net, critical access, children's, rehabilitation, or  
345.30 long-term hospital;

345.31 (4) whether the hospital's administrative cost of compiling the necessary DSH  
345.32 reports exceeds the anticipated value of any calculated DSH payment; and

345.33 (5) whether the hospital provides specific services designated by the commissioner  
345.34 to be of particular importance to the medical assistance program.

345.35 (e) Any payments or portion of payments made to a hospital under this subdivision  
345.36 that are subsequently returned to the commissioner because the payments are found to

346.1 exceed the hospital-specific DSH limit for that hospital shall be redistributed, proportionate  
 346.2 to the number of fee-for-service discharges, to other DSH-eligible nonchildren's hospitals  
 346.3 that have a medical assistance utilization rate that is at least one standard deviation above  
 346.4 the mean.

346.5 Sec. 16. Minnesota Statutes 2014, section 256B.06, is amended by adding a  
 346.6 subdivision to read:

346.7 Subd. 6. **Legal referral and assistance grants.** (a) The commissioner shall award  
 346.8 grants to one or more nonprofit programs that provide legal services based on indigency to  
 346.9 provide legal services to individuals with emergency medical conditions or chronic health  
 346.10 conditions who are not currently eligible for medical assistance or other public health  
 346.11 care programs based on their legal status, but who may meet eligibility requirements  
 346.12 with legal assistance.

346.13 (b) The grantees, in collaboration with hospitals and safety net providers, shall  
 346.14 provide referral assistance to connect individuals identified in paragraph (a) with  
 346.15 alternative resources and services to assist in meeting their health care needs.

346.16 Sec. 17. Minnesota Statutes 2014, section 256B.0625, subdivision 9, is amended to read:

346.17 Subd. 9. **Dental services.** (a) Medical assistance covers dental services.

346.18 (b) Medical assistance dental coverage for nonpregnant adults is limited to the  
 346.19 following services:

346.20 (1) comprehensive exams, limited to once every five years;

346.21 (2) periodic exams, limited to one per year;

346.22 (3) limited exams;

346.23 (4) bitewing x-rays, limited to one per year;

346.24 (5) periapical x-rays;

346.25 (6) panoramic x-rays or full-mouth series of x-rays, limited to ~~one~~ once every five  
 346.26 years except (1) when medically necessary for the diagnosis and follow-up of oral and  
 346.27 maxillofacial pathology and trauma or (2) once every two years for patients who cannot  
 346.28 cooperate for intraoral film due to a developmental disability or medical condition that  
 346.29 does not allow for intraoral film placement;

346.30 (7) prophylaxis, limited to one per year;

346.31 (8) application of fluoride varnish, limited to one per year;

346.32 (9) posterior fillings, all at the amalgam rate;

346.33 (10) anterior fillings;

346.34 (11) endodontics, limited to root canals on the anterior and premolars only;

347.1 (12) removable prostheses, each dental arch limited to one every six years;

347.2 (13) oral surgery, limited to extractions, biopsies, and incision and drainage of  
347.3 abscesses;

347.4 (14) palliative treatment and sedative fillings for relief of pain; ~~and~~

347.5 (15) full-mouth debridement, limited to one every five years; and

347.6 (16) nonsurgical treatment for periodontal disease, including scaling, root planing,  
347.7 and routine periodontal maintenance procedures, limited to once per quadrant per year.

347.8 (c) In addition to the services specified in paragraph (b), medical assistance  
347.9 covers the following services for adults, if provided in an outpatient hospital setting or  
347.10 freestanding ambulatory surgical center as part of outpatient dental surgery:

347.11 (1) periodontics, limited to periodontal scaling and root planing once every ~~two~~  
347.12 years year;

347.13 (2) general anesthesia; and

347.14 ~~(3) full-mouth survey once every five years~~

347.15 (3) a comprehensive oral examination and full-mouth series of x-rays.

347.16 (d) Medical assistance covers medically necessary dental services for children and  
347.17 pregnant women. The following guidelines apply:

347.18 (1) posterior fillings are paid at the amalgam rate;

347.19 (2) application of sealants are covered once every five years per permanent molar for  
347.20 children only;

347.21 (3) application of fluoride varnish is covered once every six months; and

347.22 (4) orthodontia is eligible for coverage for children only.

347.23 (e) In addition to the services specified in paragraphs (b) and (c), medical assistance  
347.24 covers the following services for adults:

347.25 (1) house calls or extended care facility calls for on-site delivery of covered services;

347.26 (2) behavioral management when additional staff time is required to accommodate  
347.27 behavioral challenges and sedation is not used;

347.28 (3) oral or IV sedation, if the covered dental service cannot be performed safely  
347.29 without it or would otherwise require the service to be performed under general anesthesia  
347.30 in a hospital or surgical center; and

347.31 (4) prophylaxis, in accordance with an appropriate individualized treatment plan, but  
347.32 no more than four times per year.

347.33 (f) The commissioner shall not require prior authorization for the services included  
347.34 in paragraph (e), clauses (1) to (3), and shall prohibit managed care and county-based  
347.35 purchasing plans from requiring prior authorization for the services included in paragraph  
347.36 (e), clauses (1) to (3), when provided under sections 256B.69, 256B.692, and 256L.12.

348.1 Sec. 18. Minnesota Statutes 2014, section 256B.0625, is amended by adding a  
348.2 subdivision to read:

348.3 Subd. 9b. **Dental services provided by faculty members and resident dentists**  
348.4 **at a dental school.** (a) A dentist who is not enrolled as a medical assistance provider,  
348.5 is a faculty or adjunct member at the University of Minnesota or a resident dentist  
348.6 licensed under section 150A.06, subdivision 1b, and is providing dental services at a  
348.7 dental clinic owned or operated by the University of Minnesota, may be enrolled as a  
348.8 medical assistance provider if the provider completes and submits to the commissioner an  
348.9 agreement form developed by the commissioner. The agreement must specify that the  
348.10 faculty or adjunct member or resident dentist:

348.11 (1) will not receive payment for the services provided to medical assistance or  
348.12 MinnesotaCare enrollees performed at the dental clinics owned or operated by the  
348.13 University of Minnesota;

348.14 (2) will not be listed in the medical assistance or MinnesotaCare provider directory;  
348.15 and

348.16 (3) is not required to serve medical assistance and MinnesotaCare enrollees when  
348.17 providing nonvolunteer services in a private practice.

348.18 (b) A dentist or resident dentist enrolled under this subdivision as a fee-for-service  
348.19 provider shall not otherwise be enrolled in or receive payments from medical assistance or  
348.20 MinnesotaCare as a fee-for-service provider.

348.21 Sec. 19. Minnesota Statutes 2014, section 256B.0625, is amended by adding a  
348.22 subdivision to read:

348.23 Subd. 9c. **Prior authorization for dental services.** Effective for dental services  
348.24 rendered on or after January 1, 2016, the following prior authorization requirements  
348.25 shall apply for services provided under fee-for-service or through a managed care plan  
348.26 or county-based purchasing plan:

348.27 (1) prior authorization for a dental service shall remain valid for at least 12 months;

348.28 (2) a new prior authorization for a dental service shall not be required if a prior  
348.29 authorization for the service has already been provided within the previous 12 months  
348.30 for the same enrollee, if the enrollee changes health plans within the 12-month period in  
348.31 which the prior authorization is valid; and

348.32 (3) a managed care plan or county-based purchasing plan shall not require prior  
348.33 authorization before providing dental services to an enrollee that is more restrictive  
348.34 than the prior authorization requirements established by the commissioner for the  
348.35 fee-for-service system.

349.1 Sec. 20. Minnesota Statutes 2014, section 256B.0625, is amended by adding a  
349.2 subdivision to read:

349.3 Subd. 9d. **Administrative simplification for dental services.** By January 1,  
349.4 2016, the commissioner shall designate a uniform application form to be used in the  
349.5 credentialing of all dental providers serving persons enrolled in medical assistance and  
349.6 MinnesotaCare. The uniform application shall be developed by the commissioner in  
349.7 consultation with representatives of managed care plans, county-based purchasing plans,  
349.8 dental benefit administrators, and dental providers, and must meet the National Committee  
349.9 for Quality Assurance accreditation standards related to credentialing.

349.10 Sec. 21. Minnesota Statutes 2014, section 256B.0625, subdivision 13h, is amended to  
349.11 read:

349.12 Subd. 13h. **Medication therapy management services.** (a) Medical assistance and  
349.13 general assistance medical care cover covers medication therapy management services  
349.14 for a recipient taking three or more prescriptions to treat or prevent one or more chronic  
349.15 medical conditions; a recipient with a drug therapy problem that is identified by the  
349.16 commissioner or identified by a pharmacist and approved by the commissioner; or prior  
349.17 authorized by the commissioner that has resulted or is likely to result in significant  
349.18 nondrug program costs. The commissioner may cover medical therapy management  
349.19 services under MinnesotaCare if the commissioner determines this is cost-effective. For  
349.20 purposes of this subdivision, "medication therapy management" means the provision  
349.21 of the following pharmaceutical care services by a licensed pharmacist to optimize the  
349.22 therapeutic outcomes of the patient's medications:

349.23 (1) performing or obtaining necessary assessments of the patient's health status;

349.24 (2) formulating a medication treatment plan;

349.25 (3) monitoring and evaluating the patient's response to therapy, including safety  
349.26 and effectiveness;

349.27 (4) performing a comprehensive medication review to identify, resolve, and prevent  
349.28 medication-related problems, including adverse drug events;

349.29 (5) documenting the care delivered and communicating essential information to  
349.30 the patient's other primary care providers;

349.31 (6) providing verbal education and training designed to enhance patient  
349.32 understanding and appropriate use of the patient's medications;

349.33 (7) providing information, support services, and resources designed to enhance  
349.34 patient adherence with the patient's therapeutic regimens; and

350.1 (8) coordinating and integrating medication therapy management services within the  
350.2 broader health care management services being provided to the patient.

350.3 Nothing in this subdivision shall be construed to expand or modify the scope of practice of  
350.4 the pharmacist as defined in section 151.01, subdivision 27.

350.5 (b) To be eligible for reimbursement for services under this subdivision, a pharmacist  
350.6 must meet the following requirements:

350.7 (1) have a valid license issued by the Board of Pharmacy of the state in which the  
350.8 medication therapy management service is being performed;

350.9 (2) have graduated from an accredited college of pharmacy on or after May 1996, or  
350.10 completed a structured and comprehensive education program approved by the Board of  
350.11 Pharmacy and the American Council of Pharmaceutical Education for the provision and  
350.12 documentation of pharmaceutical care management services that has both clinical and  
350.13 didactic elements;

350.14 (3) be practicing in an ambulatory care setting as part of a multidisciplinary team or  
350.15 have developed a structured patient care process that is offered in a private or semiprivate  
350.16 patient care area that is separate from the commercial business that also occurs in the  
350.17 setting, or in home settings, including long-term care settings, group homes, and facilities  
350.18 providing assisted living services, but excluding skilled nursing facilities; and

350.19 (4) make use of an electronic patient record system that meets state standards.

350.20 (c) For purposes of reimbursement for medication therapy management services,  
350.21 the commissioner may enroll individual pharmacists as medical assistance ~~and general~~  
350.22 ~~assistance medical care~~ providers. The commissioner may also establish contact  
350.23 requirements between the pharmacist and recipient, including limiting the number of  
350.24 reimbursable consultations per recipient.

350.25 (d) If there are no pharmacists who meet the requirements of paragraph (b) practicing  
350.26 within a reasonable geographic distance of the patient, a pharmacist who meets the  
350.27 requirements may provide the services via two-way interactive video. Reimbursement  
350.28 shall be at the same rates and under the same conditions that would otherwise apply to  
350.29 the services provided. To qualify for reimbursement under this paragraph, the pharmacist  
350.30 providing the services must meet the requirements of paragraph (b), and must be  
350.31 located within an ambulatory care setting ~~approved by the commissioner~~ that meets the  
350.32 requirements of paragraph (b), clause (3). The patient must also be located within an  
350.33 ambulatory care setting ~~approved by the commissioner~~ that meets the requirements of  
350.34 paragraph (b), clause (3). Services provided under this paragraph may not be transmitted  
350.35 into the patient's residence.

351.1 ~~(e) The commissioner shall establish a pilot project for an intensive medication~~  
 351.2 ~~therapy management program for patients identified by the commissioner with multiple~~  
 351.3 ~~chronic conditions and a high number of medications who are at high risk of preventable~~  
 351.4 ~~hospitalizations, emergency room use, medication complications, and suboptimal~~  
 351.5 ~~treatment outcomes due to medication-related problems. For purposes of the pilot~~  
 351.6 ~~project, medication therapy management services may be provided in a patient's home~~  
 351.7 ~~or community setting, in addition to other authorized settings. The commissioner may~~  
 351.8 ~~waive existing payment policies and establish special payment rates for the pilot project.~~  
 351.9 ~~The pilot project must be designed to produce a net savings to the state compared to the~~  
 351.10 ~~estimated costs that would otherwise be incurred for similar patients without the program.~~  
 351.11 ~~The pilot project must begin by January 1, 2010, and end June 30, 2012.~~

351.12 (e) Medication therapy management services may be delivered into a patient's  
 351.13 residence via secure interactive video if the medication therapy management services  
 351.14 are performed electronically during a covered home care visit by an enrolled provider.  
 351.15 Reimbursement shall be at the same rates and under the same conditions that would  
 351.16 otherwise apply to the services provided. To qualify for reimbursement under this  
 351.17 paragraph, the pharmacist providing the services must meet the requirements of paragraph  
 351.18 (b) and must be located within an ambulatory care setting that meets the requirements of  
 351.19 paragraph (b), clause (3).

351.20 Sec. 22. Minnesota Statutes 2014, section 256B.0625, subdivision 14, is amended to  
 351.21 read:

351.22 Subd. 14. **Diagnostic, screening, and preventive services.** (a) Medical assistance  
 351.23 covers diagnostic, screening, and preventive services.

351.24 (b) "Preventive services" include services related to pregnancy, including:

351.25 (1) services for those conditions which may complicate a pregnancy and which may  
 351.26 be available to a pregnant woman determined to be at risk of poor pregnancy outcome;

351.27 (2) prenatal HIV risk assessment, education, counseling, and testing; and

351.28 (3) alcohol abuse assessment, education, and counseling on the effects of alcohol  
 351.29 usage while pregnant. Preventive services available to a woman at risk of poor pregnancy  
 351.30 outcome may differ in an amount, duration, or scope from those available to other  
 351.31 individuals eligible for medical assistance.

351.32 (c) "Screening services" include, but are not limited to;

351.33 (1) blood lead tests; and

351.34 (2) oral health screenings, using the risk factors established by the American  
 351.35 Academies of Pediatrics and Pediatric Dentistry, conducted by a licensed dental provider

352.1 in collaborative practice under section 150A.10, subdivision 1a, 150A.105, or 150A.106,  
 352.2 to determine an enrollee's need to be seen by a dentist for diagnosis and assessment  
 352.3 to identify possible signs of oral or systemic disease, malformation, or injury and the  
 352.4 potential need for referral for diagnosis and treatment. For purposes of this paragraph, oral  
 352.5 health screenings are limited to once per year, and the provider performing the screening  
 352.6 must have an agreement in effect that refers those needing necessary follow-up care to  
 352.7 a licensed dentist where the necessary care is provided.

352.8 (d) The commissioner shall encourage, at the time of the child and teen checkup or  
 352.9 at an episodic care visit, the primary care health care provider to perform primary caries  
 352.10 preventive services. Primary caries preventive services include, at a minimum:

352.11 (1) a general visual examination of the child's mouth without using probes or other  
 352.12 dental equipment or taking radiographs;

352.13 (2) a risk assessment using the factors established by the American Academies  
 352.14 of Pediatrics and Pediatric Dentistry; and

352.15 (3) the application of a fluoride varnish beginning at age one to those children  
 352.16 assessed by the provider as being high risk in accordance with best practices as defined by  
 352.17 the Department of Human Services. The provider must obtain parental or legal guardian  
 352.18 consent before a fluoride varnish is applied to a minor child's teeth.

352.19 At each checkup, if primary caries preventive services are provided, the provider must  
 352.20 provide to the child's parent or legal guardian: information on caries etiology and  
 352.21 prevention; and information on the importance of finding a dental home for their child  
 352.22 by the age of one. The provider must also advise the parent or legal guardian to contact  
 352.23 the child's managed care plan or the Department of Human Services in order to secure a  
 352.24 dental appointment with a dentist. The provider must indicate in the child's medical record  
 352.25 that the parent or legal guardian was provided with this information and document any  
 352.26 primary caries prevention services provided to the child.

352.27 Sec. 23. Minnesota Statutes 2014, section 256B.0625, subdivision 17, is amended to  
 352.28 read:

352.29 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation  
 352.30 service" means motor vehicle transportation provided by a public or private person  
 352.31 that serves Minnesota health care program beneficiaries who do not require emergency  
 352.32 ambulance service, as defined in section 144E.001, subdivision 3, to obtain covered  
 352.33 medical services. ~~Nonemergency medical transportation service includes, but is not~~  
 352.34 ~~limited to, special transportation service, defined in section 174.29, subdivision 1.~~



353.1 (b) Medical assistance covers medical transportation costs incurred solely for  
353.2 obtaining emergency medical care or transportation costs incurred by eligible persons in  
353.3 obtaining emergency or nonemergency medical care when paid directly to an ambulance  
353.4 company, common carrier, or other recognized providers of transportation services.

353.5 Medical transportation must be provided by:

353.6 (1) nonemergency medical transportation providers who meet the requirements  
353.7 of this subdivision;

353.8 (2) ambulances, as defined in section 144E.001, subdivision 2;

353.9 (3) taxicabs ~~and~~;

353.10 (4) public transit, as defined in section 174.22, subdivision 7; or

353.11 ~~(4)~~ (5) not-for-hire vehicles, including volunteer drivers.

353.12 (c) Medical assistance covers nonemergency medical transportation provided by  
353.13 nonemergency medical transportation providers enrolled in the Minnesota health care  
353.14 programs. All nonemergency medical transportation providers must comply with the  
353.15 operating standards for special transportation service as defined in sections 174.29 to  
353.16 174.30 and Minnesota Rules, chapter 8840, and in consultation with the Minnesota  
353.17 Department of Transportation. All nonemergency medical transportation providers shall  
353.18 bill for nonemergency medical transportation services in accordance with Minnesota  
353.19 health care programs criteria. Publicly operated transit systems, volunteers, and  
353.20 not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

353.21 (d) The administrative agency of nonemergency medical transportation must:

353.22 (1) adhere to the policies defined by the commissioner in consultation with the  
353.23 Nonemergency Medical Transportation Advisory Committee;

353.24 (2) pay nonemergency medical transportation providers for services provided to  
353.25 Minnesota health care programs beneficiaries to obtain covered medical services;

353.26 (3) provide data monthly to the commissioner on appeals, complaints, no-shows,  
353.27 canceled trips, and number of trips by mode; and

353.28 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a Web-based single  
353.29 administrative structure assessment tool that meets the technical requirements established  
353.30 by the commissioner, reconciles trip information with claims being submitted by  
353.31 providers, and ensures prompt payment for nonemergency medical transportation services.

353.32 (e) Until the commissioner implements the single administrative structure and  
353.33 delivery system under subdivision 18e, clients shall obtain their level-of-service certificate  
353.34 from the commissioner or an entity approved by the commissioner that does not dispatch  
353.35 rides for clients using modes of transportation under paragraph (h), clauses (4), (5), (6),  
353.36 and (7).

354.1 (f) The commissioner may use an order by the recipient's attending physician or a  
354.2 medical or mental health professional to certify that the recipient requires nonemergency  
354.3 medical transportation services. Nonemergency medical transportation providers shall  
354.4 perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted  
354.5 service includes passenger pickup at and return to the individual's residence or place of  
354.6 business, assistance with admittance of the individual to the medical facility, and assistance  
354.7 in passenger securement or in securing of wheelchairs or stretchers in the vehicle.  
354.8 ~~Nonemergency medical transportation providers must have trip logs, which include pickup  
354.9 and drop-off times, signed by the medical provider or client attesting mileage traveled to  
354.10 obtain covered medical services, whichever is deemed most appropriate. Nonemergency  
354.11 medical transportation providers may not bill for separate base rates for the continuation  
354.12 of a trip beyond the original destination. Nonemergency medical transportation providers  
354.13 must take clients to the health care provider, using the most direct route, and must not  
354.14 exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty  
354.15 care provider, unless the client receives authorization from the local agency. The minimum  
354.16 medical assistance reimbursement rates for special transportation services are:~~

354.17 ~~(1)(i) \$17 for the base rate and \$1.35 per mile for special transportation services to  
354.18 eligible persons who need a wheelchair-accessible van;~~

354.19 ~~(ii) \$11.50 for the base rate and \$1.30 per mile for special transportation services to  
354.20 eligible persons who do not need a wheelchair-accessible van; and~~

354.21 ~~(iii) \$60 for the base rate and \$2.40 per mile, and an attendant rate of \$9 per trip,  
354.22 for special transportation services to eligible persons who need a stretcher-accessible  
354.23 vehicle; and~~

354.24 ~~(2) Nonemergency medical transportation providers must take clients to the health  
354.25 care provider using the most direct route, and must not exceed 30 miles for a trip to a  
354.26 primary care provider or 60 miles for a trip to a specialty care provider, unless the client  
354.27 receives authorization from the local agency.~~

354.28 ~~Nonemergency medical transportation providers may not bill for separate base rates  
354.29 for the continuation of a trip beyond the original destination. Nonemergency medical  
354.30 transportation providers must maintain trip logs, which include pickup and drop-off times,  
354.31 signed by the medical provider or client, whichever is deemed most appropriate, attesting  
354.32 to mileage traveled to obtain covered medical services. Clients requesting client mileage  
354.33 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical  
354.34 services.~~

354.35 ~~(g) The covered modes of nonemergency medical transportation include  
354.36 transportation provided directly by clients or family members of clients with their own~~

355.1 ~~transportation, volunteers using their own vehicles, taxicabs, and public transit, or~~  
 355.2 ~~provided to a client who needs a stretcher-accessible vehicle, a lift/ramp equipped vehicle,~~  
 355.3 ~~or a vehicle that is not stretcher-accessible or lift/ramp equipped designed to transport ten~~  
 355.4 ~~or fewer persons. Upon implementation of a new rate structure, a new covered mode of~~  
 355.5 ~~nonemergency medical transportation shall include transportation provided to a client who~~  
 355.6 ~~needs a protected vehicle that is not an ambulance or police car and has safety locks, a~~  
 355.7 ~~video recorder, and a transparent thermoplastic partition between the passenger and the~~  
 355.8 ~~vehicle driver.~~

355.9 (h) (g) The administrative agency shall use the level of service process established  
 355.10 by the commissioner in consultation with the Nonemergency Medical Transportation  
 355.11 Advisory Committee to determine the client's most appropriate mode of transportation.  
 355.12 If public transit or a certified transportation provider is not available to provide the  
 355.13 appropriate service mode for the client, the client may receive a onetime service upgrade.

355.14 (h) The new covered modes of transportation, which may not be implemented  
 355.15 without a new rate structure, are:

355.16 (1) client reimbursement, which includes client mileage reimbursement provided to  
 355.17 clients who have their own transportation, or to family or an acquaintance who provides  
 355.18 transportation to the client;

355.19 (2) volunteer transport, which includes transportation by volunteers using their  
 355.20 own vehicle;

355.21 (3) unassisted transport, which includes transportation provided to a client by a  
 355.22 taxicab or public transit. If a taxicab or ~~publicly operated~~ public transit system is not  
 355.23 available, the client can receive transportation from another nonemergency medical  
 355.24 transportation provider;

355.25 (4) assisted transport, which includes transport provided to clients who require  
 355.26 assistance by a nonemergency medical transportation provider;

355.27 (5) lift-equipped/ramp transport, which includes transport provided to a client who  
 355.28 is dependent on a device and requires a nonemergency medical transportation provider  
 355.29 with a vehicle containing a lift or ramp;

355.30 (6) protected transport, which includes transport provided to a client who has  
 355.31 received a prescreening that has deemed other forms of transportation inappropriate and  
 355.32 who requires a provider: (i) with a protected vehicle that is not an ambulance or police car  
 355.33 and has safety locks, a video recorder, and a transparent thermoplastic partition between  
 355.34 the passenger and the vehicle driver; and (ii) who is certified as a protected transport  
 355.35 provider; and

356.1 (7) stretcher transport, which includes transport for a client in a prone or supine  
356.2 position and requires a nonemergency medical transportation provider with a vehicle that  
356.3 can transport a client in a prone or supine position.

356.4 (i) ~~In accordance with subdivision 18e, by July 1, 2016,~~ The local agency shall be  
356.5 the single administrative agency and shall administer and reimburse for modes defined in  
356.6 paragraph (h) according to ~~a new rate structure, once this is adopted~~ paragraphs (l) and  
356.7 (m) when the commissioner has developed, made available, and funded the Web-based  
356.8 single administrative structure, assessment tool, and level of need assessment under  
356.9 subdivision 18e. The local agency's financial obligation is limited to funds provided by  
356.10 the state or federal government.

356.11 (j) The commissioner shall:

356.12 (1) in consultation with the Nonemergency Medical Transportation Advisory  
356.13 Committee, verify that the mode and use of nonemergency medical transportation is  
356.14 appropriate;

356.15 (2) verify that the client is going to an approved medical appointment; and

356.16 (3) investigate all complaints and appeals.

356.17 (k) The administrative agency shall pay for the services provided in this subdivision  
356.18 and seek reimbursement from the commissioner, if appropriate. As vendors of medical  
356.19 care, local agencies are subject to the provisions in section 256B.041, the sanctions and  
356.20 monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160  
356.21 to 9505.2245.

356.22 (l) Payments for nonemergency medical transportation must be paid based on  
356.23 the client's assessed mode under paragraph (g), not the type of vehicle used to provide  
356.24 the service. The medical assistance reimbursement rates for nonemergency medical  
356.25 transportation services that are payable by or on behalf of the commissioner for  
356.26 nonemergency medical transportation services are:

356.27 (1) \$0.22 per mile for client reimbursement;

356.28 (2) up to 100 percent of the Internal Revenue Service business deduction rate for  
356.29 volunteer transport;

356.30 (3) equivalent to the standard fare for unassisted transport when provided by public  
356.31 transit, and \$11 for the base rate and \$1.30 per mile when provided by a nonemergency  
356.32 medical transportation provider;

356.33 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

356.34 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

356.35 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

357.1 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip  
 357.2 for an additional attendant if deemed medically necessary.

357.3 ~~The base rates for special transportation services in areas defined under RUCA~~  
 357.4 ~~to be super rural shall be equal to the reimbursement rate established in paragraph (f),~~  
 357.5 ~~clause (1), plus 11.3 percent, and for special~~ (m) The base rate for nonemergency medical  
 357.6 transportation services in areas defined under RUCA to be super rural is equal to 111.3  
 357.7 percent of the respective base rate in paragraph (l), clauses (1) to (7). The mileage rate  
 357.8 for nonemergency medical transportation services in areas defined under RUCA to be  
 357.9 rural or super rural areas is:

357.10 (1) for a trip equal to 17 miles or less, ~~mileage reimbursement shall be equal to 125~~  
 357.11 ~~percent of the respective mileage rate in paragraph (f) (l), clause clauses (1) to (7); and~~

357.12 (2) for a trip between 18 and 50 miles, ~~mileage reimbursement shall be equal to~~  
 357.13 ~~112.5 percent of the respective mileage rate in paragraph (f) (l), clause clauses (1) to (7).~~

357.14 ~~(m) (n)~~ (n) For purposes of reimbursement rates for ~~special nonemergency medical~~  
 357.15 ~~transportation services under paragraph (e) paragraphs (l) and (m), the zip code of the~~  
 357.16 ~~recipient's place of residence shall determine whether the urban, rural, or super rural~~  
 357.17 ~~reimbursement rate applies.~~

357.18 ~~(n) (o)~~ (o) For purposes of this subdivision, "rural urban commuting area" or "RUCA"  
 357.19 means a census-tract based classification system under which a geographical area is  
 357.20 determined to be urban, rural, or super rural.

357.21 ~~(o) Effective for services provided on or after September 1, 2011, nonemergency~~  
 357.22 ~~transportation rates, including special transportation, taxi, and other commercial carriers,~~  
 357.23 ~~are reduced 4.5 percent. Payments made to managed care plans and county-based~~  
 357.24 ~~purchasing plans must be reduced for services provided on or after January 1, 2012,~~  
 357.25 ~~to reflect this reduction.~~

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

357.27 Sec. 24. Minnesota Statutes 2014, section 256B.0625, subdivision 17a, is amended to  
 357.28 read:

357.29 Subd. 17a. **Payment for ambulance services.** ~~(a)~~ Medical assistance covers  
 357.30 ambulance services. Providers shall bill ambulance services according to Medicare  
 357.31 criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective  
 357.32 for services rendered on or after July 1, 2001, medical assistance payments for ambulance  
 357.33 services shall be paid at the Medicare reimbursement rate or at the medical assistance  
 357.34 payment rate in effect on July 1, 2000, whichever is greater.

358.1 ~~(b) Effective for services provided on or after September 1, 2011, ambulance~~  
358.2 ~~services payment rates are reduced 4.5 percent. Payments made to managed care plans~~  
358.3 ~~and county-based purchasing plans must be reduced for services provided on or after~~  
358.4 ~~January 1, 2012, to reflect this reduction.~~

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

358.6 Sec. 25. Minnesota Statutes 2014, section 256B.0625, subdivision 18a, is amended to  
358.7 read:

358.8 Subd. 18a. **Access to medical services.** (a) Medical assistance reimbursement for  
358.9 meals for persons traveling to receive medical care may not exceed \$5.50 for breakfast,  
358.10 \$6.50 for lunch, or \$8 for dinner.

358.11 (b) Medical assistance reimbursement for lodging for persons traveling to receive  
358.12 medical care may not exceed \$50 per day unless prior authorized by the local agency.

358.13 ~~(c) Medical assistance direct mileage reimbursement to the eligible person or the~~  
358.14 ~~eligible person's driver may not exceed 20 cents per mile.~~

358.15 ~~(d)~~ Regardless of the number of employees that an enrolled health care provider  
358.16 may have, medical assistance covers sign and oral language interpreter services when  
358.17 provided by an enrolled health care provider during the course of providing a direct,  
358.18 person-to-person covered health care service to an enrolled recipient with limited English  
358.19 proficiency or who has a hearing loss and uses interpreting services. Coverage for  
358.20 face-to-face oral language interpreter services shall be provided only if the oral language  
358.21 interpreter used by the enrolled health care provider is listed in the registry or roster  
358.22 established under section 144.058.

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

358.24 Sec. 26. Minnesota Statutes 2014, section 256B.0625, subdivision 18e, is amended to  
358.25 read:

358.26 Subd. 18e. **Single administrative structure and delivery system.** The  
358.27 commissioner, in coordination with the commissioner of transportation, shall implement  
358.28 a single administrative structure and delivery system for nonemergency medical  
358.29 transportation, beginning the latter of the date the single administrative assessment tool  
358.30 required in this subdivision is available for use, as determined by the commissioner or by  
358.31 July 1, 2016.

358.32 In coordination with the Department of Transportation, the commissioner shall  
358.33 develop and authorize a Web-based single administrative structure and assessment

359.1 tool, which must operate 24 hours a day, seven days a week, to facilitate the enrollee  
359.2 assessment process for nonemergency medical transportation services. The Web-based  
359.3 tool shall facilitate the transportation eligibility determination process initiated by clients  
359.4 and client advocates; shall include an accessible automated intake and assessment  
359.5 process and real-time identification of level of service eligibility; and shall authorize an  
359.6 appropriate and auditable mode of transportation authorization. The tool shall provide a  
359.7 single framework for reconciling trip information with claiming and collecting complaints  
359.8 regarding inappropriate level of need determinations, inappropriate transportation modes  
359.9 utilized, and interference with accessing nonemergency medical transportation. The  
359.10 Web-based single administrative structure shall operate on a trial basis for one year from  
359.11 implementation and, if approved by the commissioner, shall be permanent thereafter.  
359.12 The commissioner shall seek input from the Nonemergency Medical Transportation  
359.13 Advisory Committee to ensure the software is effective and user-friendly and make  
359.14 recommendations regarding funding of the single administrative system.

359.15 **EFFECTIVE DATE.** This section is effective July 1, 2015.

359.16 Sec. 27. Minnesota Statutes 2014, section 256B.0625, subdivision 31, is amended to  
359.17 read:

359.18 Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical  
359.19 supplies and equipment. Separate payment outside of the facility's payment rate shall  
359.20 be made for wheelchairs and wheelchair accessories for recipients who are residents  
359.21 of intermediate care facilities for the developmentally disabled. Reimbursement for  
359.22 wheelchairs and wheelchair accessories for ICF/DD recipients shall be subject to the same  
359.23 conditions and limitations as coverage for recipients who do not reside in institutions. A  
359.24 wheelchair purchased outside of the facility's payment rate is the property of the recipient.  
359.25 ~~The commissioner may set reimbursement rates for specified categories of medical~~  
359.26 ~~supplies at levels below the Medicare payment rate.~~

359.27 (b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies  
359.28 must enroll as a Medicare provider.

359.29 (c) When necessary to ensure access to durable medical equipment, prosthetics,  
359.30 orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare  
359.31 enrollment requirement if:

359.32 (1) the vendor supplies only one type of durable medical equipment, prosthetic,  
359.33 orthotic, or medical supply;

359.34 (2) the vendor serves ten or fewer medical assistance recipients per year;

360.1 (3) the commissioner finds that other vendors are not available to provide same or  
360.2 similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

360.3 (4) the vendor complies with all screening requirements in this chapter and Code of  
360.4 Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from  
360.5 the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare  
360.6 and Medicaid Services approved national accreditation organization as complying with  
360.7 the Medicare program's supplier and quality standards and the vendor serves primarily  
360.8 pediatric patients.

360.9 (d) Durable medical equipment means a device or equipment that:

360.10 (1) can withstand repeated use;

360.11 (2) is generally not useful in the absence of an illness, injury, or disability; and

360.12 (3) is provided to correct or accommodate a physiological disorder or physical  
360.13 condition or is generally used primarily for a medical purpose.

360.14 (e) Electronic tablets may be considered durable medical equipment if the electronic  
360.15 tablet will be used as an augmentative and alternative communication system as defined  
360.16 under subdivision 31a, paragraph (a). To be covered by medical assistance, the device  
360.17 must be locked in order to prevent use not related to communication.

360.18 Sec. 28. Minnesota Statutes 2014, section 256B.0625, subdivision 57, is amended to  
360.19 read:

360.20 Subd. 57. **Payment for Part B Medicare crossover claims.** (a) Effective for  
360.21 services provided on or after January 1, 2012, medical assistance payment for an enrollee's  
360.22 cost-sharing associated with Medicare Part B is limited to an amount up to the medical  
360.23 assistance total allowed, when the medical assistance rate exceeds the amount paid by  
360.24 Medicare.

360.25 (b) Excluded from this limitation are payments for mental health services and  
360.26 payments for dialysis services provided to end-stage renal disease patients. The exclusion  
360.27 for mental health services does not apply to payments for physician services provided by  
360.28 psychiatrists and advanced practice nurses with a specialty in mental health.

360.29 (c) Excluded from this limitation are payments to federally qualified health centers  
360.30 and rural health clinics.

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

360.32 Sec. 29. Minnesota Statutes 2014, section 256B.0625, subdivision 58, is amended to  
360.33 read:



361.1 Subd. 58. **Early and periodic screening, diagnosis, and treatment services.**

361.2 Medical assistance covers early and periodic screening, diagnosis, and treatment services  
 361.3 (EPSDT). The payment amount for a complete EPSDT screening shall not include charges  
 361.4 for ~~vaccines~~ health care services and products that are available at no cost to the provider  
 361.5 and shall not exceed the rate established per Minnesota Rules, part 9505.0445, item M,  
 361.6 effective October 1, 2010.

361.7 Sec. 30. Minnesota Statutes 2014, section 256B.0631, is amended to read:

361.8 **256B.0631 MEDICAL ASSISTANCE CO-PAYMENTS.**

361.9 Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical  
 361.10 assistance benefit plan shall include the following cost-sharing for all recipients, effective  
 361.11 for services provided on or after September 1, 2011:

361.12 (1) \$3 per nonpreventive visit, except as provided in paragraph (b). For purposes  
 361.13 of this subdivision, a visit means an episode of service which is required because of  
 361.14 a recipient's symptoms, diagnosis, or established illness, and which is delivered in an  
 361.15 ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse  
 361.16 midwife, advanced practice nurse, audiologist, optician, or optometrist;

361.17 (2) \$3.50 for nonemergency visits to a hospital-based emergency room, except that  
 361.18 this co-payment shall be increased to \$20 upon federal approval;

361.19 (3) \$3 per brand-name drug prescription and \$1 per generic drug prescription,  
 361.20 subject to a \$12 per month maximum for prescription drug co-payments. No co-payments  
 361.21 shall apply to antipsychotic drugs when used for the treatment of mental illness;

361.22 (4) ~~effective January 1, 2012, a family deductible equal to the maximum amount~~  
 361.23 ~~allowed under Code of Federal Regulations, title 42, part 447.54~~ \$2.75 per month per  
 361.24 family and adjusted annually by the percentage increase in the medical care component  
 361.25 of the CPI-U for the period of September to September of the preceding calendar year,  
 361.26 rounded to the next higher five-cent increment; and

361.27 (5) ~~for individuals identified by the commissioner with income at or below 100~~  
 361.28 ~~percent of the federal poverty guidelines, total monthly cost-sharing must not exceed five~~  
 361.29 ~~percent of family income. For purposes of this paragraph, family income is the total~~  
 361.30 ~~earned and unearned income of the individual and the individual's spouse, if the spouse is~~  
 361.31 ~~enrolled in medical assistance and also subject to the five percent limit on cost-sharing.~~  
 361.32 This paragraph does not apply to premiums charged to individuals described under section  
 361.33 256B.057, subdivision 9.

361.34 (b) Recipients of medical assistance are responsible for all co-payments and  
 361.35 deductibles in this subdivision.

362.1 (c) Notwithstanding paragraph (b), the commissioner, through the contracting  
362.2 process under sections 256B.69 and 256B.692, may allow managed care plans and  
362.3 county-based purchasing plans to waive the family deductible under paragraph (a),  
362.4 clause (4). The value of the family deductible shall not be included in the capitation  
362.5 payment to managed care plans and county-based purchasing plans. Managed care plans  
362.6 and county-based purchasing plans shall certify annually to the commissioner the dollar  
362.7 value of the family deductible.

362.8 (d) Notwithstanding paragraph (b), the commissioner may waive the collection of  
362.9 the family deductible described under paragraph (a), clause (4), from individuals and  
362.10 allow long-term care and waived service providers to assume responsibility for payment.

362.11 (e) Notwithstanding paragraph (b), the commissioner, through the contracting  
362.12 process under section 256B.0756 shall allow the pilot program in Hennepin County to  
362.13 waive co-payments. The value of the co-payments shall not be included in the capitation  
362.14 payment amount to the integrated health care delivery networks under the pilot program.

362.15 Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following  
362.16 exceptions:

362.17 (1) children under the age of 21;

362.18 (2) pregnant women for services that relate to the pregnancy or any other medical  
362.19 condition that may complicate the pregnancy;

362.20 (3) recipients expected to reside for at least 30 days in a hospital, nursing home, or  
362.21 intermediate care facility for the developmentally disabled;

362.22 (4) recipients receiving hospice care;

362.23 (5) 100 percent federally funded services provided by an Indian health service;

362.24 (6) emergency services;

362.25 (7) family planning services;

362.26 (8) services that are paid by Medicare, resulting in the medical assistance program  
362.27 paying for the coinsurance and deductible;

362.28 (9) co-payments that exceed one per day per provider for nonpreventive visits,  
362.29 eyeglasses, and nonemergency visits to a hospital-based emergency room; and

362.30 (10) services, fee-for-service payments subject to volume purchase through  
362.31 competitive bidding;

362.32 (11) American Indians who meet the requirements in Code of Federal Regulations,  
362.33 title 42, section 447.51;

362.34 (12) persons needing treatment for breast or cervical cancer as described under  
362.35 section 256B.057, subdivision 10; and

363.1 (13) services that currently have a rating of A or B from the United States Preventive  
363.2 Services Task Force (USPSTF), immunizations recommended by the Advisory Committee  
363.3 on Immunization Practices of the Centers for Disease Control and Prevention, and  
363.4 preventive services and screenings provided to women as described in Code of Federal  
363.5 Regulations, title 45, section 147.130.

363.6 Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall  
363.7 be reduced by the amount of the co-payment or deductible, except that reimbursements  
363.8 shall not be reduced:

363.9 (1) once a recipient has reached the \$12 per month maximum for prescription drug  
363.10 co-payments; or

363.11 (2) for a recipient ~~identified by the commissioner under 100 percent of the federal~~  
363.12 ~~poverty guidelines~~ who has met their monthly five percent cost-sharing limit.

363.13 (b) The provider collects the co-payment or deductible from the recipient. Providers  
363.14 may not deny services to recipients who are unable to pay the co-payment or deductible.

363.15 (c) Medical assistance reimbursement to fee-for-service providers and payments to  
363.16 managed care plans shall not be increased as a result of the removal of co-payments or  
363.17 deductibles effective on or after January 1, 2009.

363.18 **EFFECTIVE DATE.** The amendment to subdivision 1, paragraph (a), clause (4), is  
363.19 effective retroactively from January 1, 2014.

363.20 Sec. 31. **[256B.0638] OPIOID PRESCRIBING IMPROVEMENT PROGRAM.**

363.21 Subdivision 1. **Program established.** The commissioner of human services, in  
363.22 conjunction with the commissioner of health, shall coordinate and implement an opioid  
363.23 prescribing improvement program to reduce opioid dependency and substance use by  
363.24 Minnesotans due to the prescribing of opioid analgesics by health care providers.

363.25 Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this  
363.26 subdivision have the meanings given them.

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

363.28 (c) "Commissioners" means the commissioner of human services and the  
363.29 commissioner of health.

363.30 (d) "DEA" means the United States Drug Enforcement Administration.

363.31 (e) "Minnesota health care program" means a public health care program  
363.32 administered by the commissioner of human services under chapters 256B and 256L, and  
363.33 the Minnesota restricted recipient program.

364.1 (f) "Opioid disenrollment standards" means parameters of opioid prescribing  
364.2 practices that fall outside community standard thresholds for prescribing to such a degree  
364.3 that a provider must be disenrolled as a medical assistance provider.

364.4 (g) "Opioid prescriber" means a licensed health care provider who prescribes opioids  
364.5 to medical assistance and MinnesotaCare enrollees under the fee-for-service system or  
364.6 under a managed care or county-based purchasing plan.

364.7 (h) "Opioid quality improvement standard thresholds" means parameters of opioid  
364.8 prescribing practices that fall outside community standards for prescribing to such a  
364.9 degree that quality improvement is required.

364.10 (i) "Program" means the statewide opioid prescribing improvement program  
364.11 established under this section.

364.12 (j) "Provider group" means a clinic, hospital, or primary or specialty practice group  
364.13 that employs, contracts with, or is affiliated with an opioid prescriber. Provider group does  
364.14 not include a professional association supported by dues-paying members.

364.15 (k) "Sentinel measures" means measures of opioid use that identify variations in  
364.16 prescribing practices during the prescribing intervals.

364.17 Subd. 3. **Opioid prescribing work group.** (a) The commissioner of human  
364.18 services, in consultation with the commissioner of health, shall appoint the following  
364.19 voting members to an opioid prescribing work group:

364.20 (1) two consumer members who have been impacted by an opioid abuse disorder or  
364.21 opioid dependence disorder, either personally or with family members;

364.22 (2) one member who is a licensed physician actively practicing in Minnesota and  
364.23 registered as a practitioner with the DEA;

364.24 (3) one member who is a licensed pharmacist actively practicing in Minnesota and  
364.25 registered as a practitioner with the DEA;

364.26 (4) one member who is a licensed nurse practitioner actively practicing in Minnesota  
364.27 and registered as a practitioner with the DEA;

364.28 (5) one member who is a licensed dentist actively practicing in Minnesota and  
364.29 registered as a practitioner with the DEA;

364.30 (6) two members who are nonphysician licensed health care professionals actively  
364.31 engaged in the practice of their profession in Minnesota, and their practice includes  
364.32 treating pain;

364.33 (7) one member who is a mental health professional who is licensed or registered  
364.34 in a mental health profession, who is actively engaged in the practice of that profession  
364.35 in Minnesota, and whose practice includes treating patients with chemical dependency  
364.36 or substance abuse;

- 365.1 (8) one member who is a medical examiner for a Minnesota county;
- 365.2 (9) one member of the Health Services Policy Committee established under section
- 365.3 256B.0625, subdivisions 3c to 3e;
- 365.4 (10) one member who is a medical director of a health plan company doing business
- 365.5 in Minnesota;
- 365.6 (11) one member who is a pharmacy director of a health plan company doing
- 365.7 business in Minnesota; and
- 365.8 (12) one member representing Minnesota law enforcement.
- 365.9 (b) In addition, the work group shall include the following nonvoting members:
- 365.10 (1) the medical director for the medical assistance program;
- 365.11 (2) a member representing the Department of Human Services pharmacy unit; and
- 365.12 (3) the medical director for the Department of Labor and Industry.
- 365.13 (c) An honorarium of \$200 per meeting and reimbursement for mileage and parking
- 365.14 shall be paid to each voting member in attendance.
- 365.15 Subd. 4. **Program components.** (a) The working group shall recommend to the
- 365.16 commissioners the components of the statewide opioid prescribing improvement program,
- 365.17 including, but not limited to, the following:
- 365.18 (1) developing criteria for opioid prescribing protocols, including:
- 365.19 (i) prescribing for the interval of up to four days immediately after an acute painful
- 365.20 event;
- 365.21 (ii) prescribing for the interval of up to 45 days after an acute painful event; and
- 365.22 (iii) prescribing for chronic pain, which for purposes of this program means pain
- 365.23 lasting longer than 45 days after an acute painful event;
- 365.24 (2) developing sentinel measures;
- 365.25 (3) developing educational resources for opioid prescribers about communicating
- 365.26 with patients about pain management and the use of opioids to treat pain;
- 365.27 (4) developing opioid quality improvement standard thresholds and opioid
- 365.28 disenrollment standards for opioid prescribers and provider groups. In developing opioid
- 365.29 disenrollment standards, the standards may be described in terms of the length of time in
- 365.30 which prescribing practices fall outside community standards and the nature and amount
- 365.31 of opioid prescribing that fall outside community standards; and
- 365.32 (5) addressing other program issues as determined by the commissioners.
- 365.33 (b) The opioid prescribing protocols shall not apply to opioids prescribed for patients
- 365.34 who are experiencing pain caused by a malignant condition or who are receiving hospice
- 365.35 care, or to opioids prescribed as medication-assisted therapy to treat opioid dependency.

366.1 (c) All opioid prescribers who prescribe opioids to Minnesota health care program  
366.2 enrollees must participate in the program in accordance with subdivision 5. Any other  
366.3 prescriber who prescribes opioids may comply with the components of this program  
366.4 described in paragraph (a) on a voluntary basis.

366.5 Subd. 5. **Program implementation.** (a) The commissioner shall implement the  
366.6 programs within the Minnesota health care program to improve the health of and quality  
366.7 of care provided to Minnesota health care program enrollees. The commissioner shall  
366.8 annually collect and report to opioid prescribers data showing the sentinel measures of  
366.9 their opioid prescribing patterns compared to their anonymized peers.

366.10 (b) The commissioner shall notify an opioid prescriber and all provider groups  
366.11 with which the opioid prescriber is employed or affiliated when the opioid prescriber's  
366.12 prescribing pattern exceeds the opioid quality improvement standard thresholds. An  
366.13 opioid prescriber and any provider group that receives a notice under this paragraph shall  
366.14 submit to the commissioner a quality improvement plan for review and approval by the  
366.15 commissioner with the goal of bringing the opioid prescriber's prescribing practices into  
366.16 alignment with community standards. A quality improvement plan must include:

366.17 (1) components of the program described in subdivision 4, paragraph (a);

366.18 (2) internal practice-based measures to review the prescribing practice of the  
366.19 opioid prescriber and, where appropriate, any other opioid prescribers employed by or  
366.20 affiliated with any of the provider groups with which the opioid prescriber is employed or  
366.21 affiliated; and

366.22 (3) appropriate use of the prescription monitoring program under section 152.126.

366.23 (c) If, after a year from the commissioner's notice under paragraph (b), the opioid  
366.24 prescriber's prescribing practices do not improve so that they are consistent with  
366.25 community standards, the commissioner shall take one or more of the following steps:

366.26 (1) monitor prescribing practices more frequently than annually;

366.27 (2) monitor more aspects of the opioid prescriber's prescribing practices than the  
366.28 sentinel measures; or

366.29 (3) require the opioid prescriber to participate in additional quality improvement  
366.30 efforts, including but not limited to mandatory use of the prescription monitoring program  
366.31 established under section 152.126.

366.32 (d) The commissioner shall terminate from Minnesota health care programs all  
366.33 opioid prescribers and provider groups whose prescribing practices fall within the  
366.34 applicable opioid disenrollment standards.

366.35 Subd. 6. **Data practices.** (a) Reports and data identifying an opioid prescriber  
366.36 are private data on individuals as defined under section 13.02, subdivision 12, until an

367.1 opioid prescriber is subject to termination as a medical assistance provider under this  
 367.2 section. Notwithstanding this data classification, the commissioner shall share with all of  
 367.3 the provider groups with which an opioid prescriber is employed or affiliated, a report  
 367.4 identifying an opioid prescriber who is subject to quality improvement activities under  
 367.5 subdivision 5, paragraph (b) or (c).

367.6 (b) Reports and data identifying a provider group are nonpublic data as defined  
 367.7 under section 13.02, subdivision 9, until the provider group is subject to termination as a  
 367.8 medical assistance provider under this section.

367.9 (c) Upon termination under this section, reports and data identifying an opioid  
 367.10 prescriber or provider group are public, except that any identifying information of  
 367.11 Minnesota health care program enrollees must be redacted by the commissioner.

367.12 Subd. 7. **Annual report to legislature.** By September 15, 2016, and annually  
 367.13 thereafter, the commissioner of human services shall report to the legislature on the  
 367.14 implementation of the opioid prescribing improvement program in the Minnesota health  
 367.15 care programs. The report must include data on the utilization of opioids within the  
 367.16 Minnesota health care programs.

367.17 Sec. 32. Minnesota Statutes 2014, section 256B.0757, is amended to read:

367.18 **256B.0757 COORDINATED CARE THROUGH A HEALTH HOME.**

367.19 Subdivision 1. **Provision of coverage.** (a) The commissioner shall provide  
 367.20 medical assistance coverage of health home services for eligible individuals with chronic  
 367.21 conditions who select a designated provider, ~~a team of health care professionals, or a~~  
 367.22 ~~health team~~ as the individual's health home.

367.23 (b) The commissioner shall implement this section in compliance with the  
 367.24 requirements of the state option to provide health homes for enrollees with chronic  
 367.25 conditions, as provided under the Patient Protection and Affordable Care Act, Public  
 367.26 Law 111-148, sections 2703 and 3502. Terms used in this section have the meaning  
 367.27 provided in that act.

367.28 (c) The commissioner shall establish health homes to serve populations with serious  
 367.29 mental illness who meet the eligibility requirements described under subdivision 2, clause  
 367.30 (4). The health home services provided by health homes shall focus on both the behavioral  
 367.31 and the physical health of these populations.

367.32 Subd. 2. **Eligible individual.** An individual is eligible for health home services  
 367.33 under this section if the individual is eligible for medical assistance under this chapter  
 367.34 and has at least:

367.35 (1) two chronic conditions;

368.1 (2) one chronic condition and is at risk of having a second chronic condition; ~~or~~  
 368.2 (3) one serious and persistent mental health condition; or  
 368.3 (4) a condition that meets the definition in section 245.462, subdivision 20,  
 368.4 paragraph (a), or 245.4871, subdivision 15, clause (2); and has a current diagnostic  
 368.5 assessment as defined in Minnesota Rules, part 9505.0372, subpart 1, item B or C, as  
 368.6 performed or reviewed by a mental health professional employed by or under contract  
 368.7 with the behavioral health home. The commissioner shall establish criteria for determining  
 368.8 continued eligibility.

368.9 Subd. 3. **Health home services.** (a) Health home services means comprehensive and  
 368.10 timely high-quality services that are provided by a health home. These services include:

- 368.11 (1) comprehensive care management;
- 368.12 (2) care coordination and health promotion;
- 368.13 (3) comprehensive transitional care, including appropriate follow-up, from inpatient  
 368.14 to other settings;
- 368.15 (4) patient and family support, including authorized representatives;
- 368.16 (5) referral to community and social support services, if relevant; and
- 368.17 (6) use of health information technology to link services, as feasible and appropriate.

368.18 (b) The commissioner shall maximize the number and type of services included  
 368.19 in this subdivision to the extent permissible under federal law, including physician,  
 368.20 outpatient, mental health treatment, and rehabilitation services necessary for  
 368.21 comprehensive transitional care following hospitalization.

368.22 Subd. 4. ~~Health teams~~ **Designated provider.** (a) Health home services  
 368.23 are voluntary and an eligible individual may choose any designated provider. The  
 368.24 commissioner shall establish ~~health teams to support the patient-centered~~ designated  
 368.25 providers to serve as health home homes and provide the services described in subdivision  
 368.26 3 to individuals eligible under subdivision 2. The commissioner shall apply for grants ~~or~~  
 368.27 ~~contracts~~ as provided under section 3502 of the Patient Protection and Affordable Care Act  
 368.28 to establish ~~health teams~~ homes and provide capitated payments to ~~primary care~~ designated  
 368.29 providers. For purposes of this section, "~~health teams~~" "designated provider" means  
 368.30 ~~community-based, interdisciplinary, interprofessional teams of health care providers that~~  
 368.31 ~~support primary care practices.~~ ~~These providers may include medical specialists, nurses,~~  
 368.32 ~~advanced practice registered nurses, pharmacists, nutritionists, social workers, behavioral~~  
 368.33 ~~and mental health providers, doctors of chiropractic, licensed complementary and~~  
 368.34 ~~alternative medicine practitioners, and physician assistants.~~ a provider, clinical practice or  
 368.35 clinical group practice, rural clinic, community health center, community mental health  
 368.36 center, or any other entity that is determined by the commissioner to be qualified to be a



369.1 health home for eligible individuals. This determination must be based on documentation  
369.2 evidencing that the designated provider has the systems and infrastructure in place to  
369.3 provide health home services and satisfies the qualification standards established by the  
369.4 commissioner in consultation with stakeholders and approved by the Centers for Medicare  
369.5 and Medicaid Services.

369.6 (b) The commissioner shall develop and implement certification standards for  
369.7 designated providers under this subdivision.

369.8 **Subd. 5. Payments.** The commissioner shall make payments to each ~~health home~~  
369.9 ~~and each health team~~ designated provider for the provision of health home services  
369.10 described in subdivision 3 to each eligible individual with chronic conditions under  
369.11 subdivision 2 that selects the health home as a provider.

369.12 **Subd. 6. Coordination.** The commissioner, to the extent feasible, shall ensure that  
369.13 the requirements and payment methods for ~~health homes and health teams~~ designated  
369.14 providers developed under this section are consistent with the requirements and payment  
369.15 methods for health care homes established under sections 256B.0751 and 256B.0753. The  
369.16 commissioner may modify requirements and payment methods under sections 256B.0751  
369.17 and 256B.0753 in order to be consistent with federal health home requirements and  
369.18 payment methods.

369.19 **Subd. 8. Evaluation and continued development.** (a) For continued certification  
369.20 under this section, health homes must meet process, outcome, and quality standards  
369.21 developed and specified by the commissioner. The commissioner shall collect data from  
369.22 health homes as necessary to monitor compliance with certification standards.

369.23 (b) The commissioner may contract with a private entity to evaluate patient and  
369.24 family experiences, health care utilization, and costs.

369.25 (c) The commissioner shall utilize findings from the implementation of behavioral  
369.26 health homes to determine populations to serve under subsequent health home models  
369.27 for individuals with chronic conditions.

369.28 **EFFECTIVE DATE.** This section is effective January 1, 2016, or upon federal  
369.29 approval, whichever is later. The commissioner of human services shall notify the revisor  
369.30 of statutes when federal approval is obtained.

369.31 **Sec. 33. [256B.0758] HEALTH CARE DELIVERY PILOT PROGRAM.**

369.32 (a) The commissioner may establish a health care delivery pilot program to test  
369.33 alternative and innovative integrated health care delivery networks, including accountable  
369.34 care organizations or a community-based collaborative care network created by or

370.1 including North Memorial Health Care. If required, the commissioner shall seek federal  
370.2 approval of a new waiver request or amend an existing demonstration pilot project waiver.

370.3 (b) Individuals eligible for the pilot program shall be individuals who are eligible for  
370.4 medical assistance under section 256B.055. The commissioner may identify individuals  
370.5 to be enrolled in the pilot program based on zip code or whether the individuals would  
370.6 benefit from an integrated health care delivery network.

370.7 (c) In developing a payment system for the pilot programs, the commissioner shall  
370.8 establish a total cost of care for the individuals enrolled in the pilot program that equals  
370.9 the cost of care that would otherwise be spent for these enrollees in the prepaid medical  
370.10 assistance program.

370.11 (d) The commissioner shall report to the chairs and ranking minority members  
370.12 of the legislative committees with jurisdiction over health and human services finance  
370.13 committees on whether an integrated health care delivery network was created by North  
370.14 Memorial Health Care, including a description of the delivery network system and the  
370.15 geographic area served by the network system.

370.16 Sec. 34. Minnesota Statutes 2014, section 256B.69, subdivision 5a, is amended to read:

370.17 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section  
370.18 and section 256L.12 shall be entered into or renewed on a calendar year basis. The  
370.19 commissioner may issue separate contracts with requirements specific to services to  
370.20 medical assistance recipients age 65 and older.

370.21 (b) A prepaid health plan providing covered health services for eligible persons  
370.22 pursuant to chapters 256B and 256L is responsible for complying with the terms of its  
370.23 contract with the commissioner. Requirements applicable to managed care programs  
370.24 under chapters 256B and 256L established after the effective date of a contract with the  
370.25 commissioner take effect when the contract is next issued or renewed.

370.26 (c) The commissioner shall withhold five percent of managed care plan payments  
370.27 under this section and county-based purchasing plan payments under section 256B.692  
370.28 for the prepaid medical assistance program pending completion of performance targets.  
370.29 Each performance target must be quantifiable, objective, measurable, and reasonably  
370.30 attainable, except in the case of a performance target based on a federal or state law  
370.31 or rule. Criteria for assessment of each performance target must be outlined in writing  
370.32 prior to the contract effective date. Clinical or utilization performance targets and their  
370.33 related criteria must consider evidence-based research and reasonable interventions when  
370.34 available or applicable to the populations served, and must be developed with input from  
370.35 external clinical experts and stakeholders, including managed care plans, county-based

371.1 purchasing plans, and providers. The managed care or county-based purchasing plan  
371.2 must demonstrate, to the commissioner's satisfaction, that the data submitted regarding  
371.3 attainment of the performance target is accurate. The commissioner shall periodically  
371.4 change the administrative measures used as performance targets in order to improve plan  
371.5 performance across a broader range of administrative services. The performance targets  
371.6 must include measurement of plan efforts to contain spending on health care services and  
371.7 administrative activities. The commissioner may adopt plan-specific performance targets  
371.8 that take into account factors affecting only one plan, including characteristics of the  
371.9 plan's enrollee population. The withheld funds must be returned no sooner than July of the  
371.10 following year if performance targets in the contract are achieved. The commissioner may  
371.11 exclude special demonstration projects under subdivision 23.

371.12 (d) The commissioner shall require that managed care plans use the assessment and  
371.13 authorization processes, forms, timelines, standards, documentation, and data reporting  
371.14 requirements, protocols, billing processes, and policies consistent with medical assistance  
371.15 fee-for-service or the Department of Human Services contract requirements consistent  
371.16 with medical assistance fee-for-service or the Department of Human Services contract  
371.17 requirements for all personal care assistance services under section 256B.0659.

371.18 (e) Effective for services rendered on or after January 1, 2012, the commissioner  
371.19 shall include as part of the performance targets described in paragraph (c) a reduction  
371.20 in the health plan's emergency department utilization rate for medical assistance and  
371.21 MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction  
371.22 shall be based on the health plan's utilization in 2009. To earn the return of the withhold  
371.23 each subsequent year, the managed care plan or county-based purchasing plan must  
371.24 achieve a qualifying reduction of no less than ten percent of the plan's emergency  
371.25 department utilization rate for medical assistance and MinnesotaCare enrollees, excluding  
371.26 enrollees in programs described in subdivisions 23 and 28, compared to the previous  
371.27 measurement year until the final performance target is reached. When measuring  
371.28 performance, the commissioner must consider the difference in health risk in a managed  
371.29 care or county-based purchasing plan's membership in the baseline year compared to the  
371.30 measurement year, and work with the managed care or county-based purchasing plan to  
371.31 account for differences that they agree are significant.

371.32 The withheld funds must be returned no sooner than July 1 and no later than July 31  
371.33 of the following calendar year if the managed care plan or county-based purchasing plan  
371.34 demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate  
371.35 was achieved. The commissioner shall structure the withhold so that the commissioner

372.1 returns a portion of the withheld funds in amounts commensurate with achieved reductions  
372.2 in utilization less than the targeted amount.

372.3 The withhold described in this paragraph shall continue for each consecutive contract  
372.4 period until the plan's emergency room utilization rate for state health care program  
372.5 enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical  
372.6 assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate  
372.7 with the health plans in meeting this performance target and shall accept payment  
372.8 withholds that may be returned to the hospitals if the performance target is achieved.

372.9 (f) Effective for services rendered on or after January 1, 2012, the commissioner  
372.10 shall include as part of the performance targets described in paragraph (c) a reduction  
372.11 in the plan's hospitalization admission rate for medical assistance and MinnesotaCare  
372.12 enrollees, as determined by the commissioner. To earn the return of the withhold each  
372.13 year, the managed care plan or county-based purchasing plan must achieve a qualifying  
372.14 reduction of no less than five percent of the plan's hospital admission rate for medical  
372.15 assistance and MinnesotaCare enrollees, excluding enrollees in programs described in  
372.16 subdivisions 23 and 28, compared to the previous calendar year until the final performance  
372.17 target is reached. When measuring performance, the commissioner must consider the  
372.18 difference in health risk in a managed care or county-based purchasing plan's membership  
372.19 in the baseline year compared to the measurement year, and work with the managed care  
372.20 or county-based purchasing plan to account for differences that they agree are significant.

372.21 The withheld funds must be returned no sooner than July 1 and no later than July  
372.22 31 of the following calendar year if the managed care plan or county-based purchasing  
372.23 plan demonstrates to the satisfaction of the commissioner that this reduction in the  
372.24 hospitalization rate was achieved. The commissioner shall structure the withhold so that  
372.25 the commissioner returns a portion of the withheld funds in amounts commensurate with  
372.26 achieved reductions in utilization less than the targeted amount.

372.27 The withhold described in this paragraph shall continue until there is a 25 percent  
372.28 reduction in the hospital admission rate compared to the hospital admission rates in  
372.29 calendar year 2011, as determined by the commissioner. The hospital admissions in this  
372.30 performance target do not include the admissions applicable to the subsequent hospital  
372.31 admission performance target under paragraph (g). Hospitals shall cooperate with the  
372.32 plans in meeting this performance target and shall accept payment withholds that may be  
372.33 returned to the hospitals if the performance target is achieved.

372.34 (g) Effective for services rendered on or after January 1, 2012, the commissioner  
372.35 shall include as part of the performance targets described in paragraph (c) a reduction in  
372.36 the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of

373.1 a previous hospitalization of a patient regardless of the reason, for medical assistance and  
373.2 MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the  
373.3 withhold each year, the managed care plan or county-based purchasing plan must achieve  
373.4 a qualifying reduction of the subsequent hospitalization rate for medical assistance and  
373.5 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23  
373.6 and 28, of no less than five percent compared to the previous calendar year until the  
373.7 final performance target is reached.

373.8 The withheld funds must be returned no sooner than July 1 and no later than July  
373.9 31 of the following calendar year if the managed care plan or county-based purchasing  
373.10 plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in  
373.11 the subsequent hospitalization rate was achieved. The commissioner shall structure the  
373.12 withhold so that the commissioner returns a portion of the withheld funds in amounts  
373.13 commensurate with achieved reductions in utilization less than the targeted amount.

373.14 The withhold described in this paragraph must continue for each consecutive  
373.15 contract period until the plan's subsequent hospitalization rate for medical assistance and  
373.16 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23  
373.17 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar  
373.18 year 2011. Hospitals shall cooperate with the plans in meeting this performance target and  
373.19 shall accept payment withholds that must be returned to the hospitals if the performance  
373.20 target is achieved.

373.21 (h) Effective for services rendered on or after January 1, 2013, through December  
373.22 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments  
373.23 under this section and county-based purchasing plan payments under section 256B.692  
373.24 for the prepaid medical assistance program. The withheld funds must be returned no  
373.25 sooner than July 1 and no later than July 31 of the following year. The commissioner may  
373.26 exclude special demonstration projects under subdivision 23.

373.27 (i) Effective for services rendered on or after January 1, 2014, the commissioner  
373.28 shall withhold three percent of managed care plan payments under this section and  
373.29 county-based purchasing plan payments under section 256B.692 for the prepaid medical  
373.30 assistance program. The withheld funds must be returned no sooner than July 1 and  
373.31 no later than July 31 of the following year. The commissioner may exclude special  
373.32 demonstration projects under subdivision 23.

373.33 (j) A managed care plan or a county-based purchasing plan under section 256B.692  
373.34 may include as admitted assets under section 62D.044 any amount withheld under this  
373.35 section that is reasonably expected to be returned.

374.1 (k) Contracts between the commissioner and a prepaid health plan are exempt from  
 374.2 the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph  
 374.3 (a), and 7.

374.4 (l) The return of the withhold under paragraphs (h) and (i) is not subject to the  
 374.5 requirements of paragraph (c).

374.6 (m) Managed care plans and county-based purchasing plans shall maintain current  
 374.7 and fully executed agreements for all subcontractors, including bargaining groups, for  
 374.8 administrative services that are expensed to the state's public health care programs.  
 374.9 Subcontractor agreements of over \$200,000 in annual payments must be in the form of a  
 374.10 written instrument or electronic document containing the elements of offer, acceptance,  
 374.11 and consideration, and must clearly indicate how they relate to state public health  
 374.12 care programs. Upon request, the commissioner shall have access to all subcontractor  
 374.13 documentation under this paragraph. Nothing in this paragraph shall allow release of  
 374.14 information that is nonpublic data pursuant to section 13.02.

374.15 Sec. 35. Minnesota Statutes 2014, section 256B.69, subdivision 5i, is amended to read:

374.16 Subd. 5i. **Administrative expenses.** ~~(a) Managed care plan and county-based~~  
 374.17 ~~purchasing plan~~ Administrative costs for a prepaid health plan provided paid to managed  
 374.18 care plans and county-based purchasing plans under this section or, section 256B.69<sub>2</sub>,  
 374.19 and section 256L.12 must not exceed by more than five 6.6 percent that prepaid health  
 374.20 plan's or county-based purchasing plan's actual calculated administrative spending for the  
 374.21 previous calendar year as a percentage of total revenue of total payments made to all  
 374.22 managed care plans and county-based purchasing plans in aggregate across all state public  
 374.23 health care programs, based on payments expected to be made at the beginning of each  
 374.24 calendar year. The penalty for exceeding this limit must be the amount of administrative  
 374.25 spending in excess of 105 percent of the actual calculated amount. The commissioner may  
 374.26 waive this penalty if the excess administrative spending is the result of unexpected shifts  
 374.27 in enrollment or member needs or new program requirements. The commissioner may  
 374.28 reduce or eliminate administrative requirements to meet the administrative cost limit.  
 374.29 For purposes of this paragraph, administrative costs do not include any state or federal  
 374.30 taxes, surcharges, or assessments.

374.31 (b) The following expenses are not allowable administrative expenses for rate-setting  
 374.32 purposes under this section:

374.33 (1) charitable contributions made by the managed care plan or the county-based  
 374.34 purchasing plan;

375.1 ~~(2) any portion of an individual's compensation in excess of \$200,000 paid by the~~  
 375.2 ~~managed care plan or county-based purchasing plan~~ compensation of individuals within  
 375.3 the organization in excess of \$200,000 such that the allocation of compensation for an  
 375.4 individual across all state public health care programs in total cannot exceed \$200,000;

375.5 (3) any penalties or fines assessed against the managed care plan or county-based  
 375.6 purchasing plan; and

375.7 (4) any indirect marketing or advertising expenses of the managed care plan or  
 375.8 county-based purchasing plan: for marketing that does not specifically target state public  
 375.9 health care programs beneficiaries and that has not been approved by the commissioner;

375.10 (5) any lobbying and political activities, events, or contributions;

375.11 (6) administrative expenses related to the provision of services not covered under  
 375.12 the state plan or waiver;

375.13 (7) alcoholic beverages and related costs;

375.14 (8) membership in any social, dining, or country club or organization; and

375.15 (9) entertainment, including amusement, diversion, and social activities, and any  
 375.16 costs directly associated with these costs, including but not limited to tickets to shows or  
 375.17 sporting events, meals, lodging, rentals, transportation, and gratuities.

375.18 For the purposes of this subdivision, compensation includes salaries, bonuses and  
 375.19 incentives, other reportable compensation on an IRS 990 form, retirement and other  
 375.20 deferred compensation, and nontaxable benefits. Contributions include payments for or to  
 375.21 any organization or entity selected by the managed care plan or county-based purchasing  
 375.22 plan that is operated for charitable, educational, political, religious, or scientific purposes  
 375.23 and not related to the provision of medical and administrative services covered under the  
 375.24 state public programs, except to the extent that they improve access to or the quality of  
 375.25 covered services for state public programs beneficiaries, or improve the health status of  
 375.26 state public health care programs beneficiaries.

375.27 (c) Administrative expenses must be reported using the formats designated by the  
 375.28 commissioner as part of the rate-setting process and must include, at a minimum, the  
 375.29 following categories:

375.30 (1) employee benefit expenses;

375.31 (2) sales expenses;

375.32 (3) general business and office expenses;

375.33 (4) taxes and assessments;

375.34 (5) consulting and professional fees; and

375.35 (6) outsourced services.

376.1 Definitions of items to be included in each category shall be provided by the commissioner  
376.2 with quarterly financial filing requirements and shall be aligned with definitions used by  
376.3 the Departments of Commerce and Health in financial reporting for commercial carriers.  
376.4 Where reasonably possible, expenses for an administrative item shall be directly allocated  
376.5 so as to assign costs for an item to an individual state public health care program when  
376.6 the cost can be specifically identified with and benefits the individual state public health  
376.7 care program. For administrative services expensed to the state's public health care  
376.8 programs, managed care plans and county-based purchasing plans must clearly identify  
376.9 and separately record expense items listed under paragraph (b) in their accounting systems  
376.10 in a manner that allows for independent verification of unallowable expenses for purposes  
376.11 of determining payment rates for state public programs.

376.12 (d) Notwithstanding paragraph (a), the commissioner shall reduce administrative  
376.13 expenses paid to managed care plans and county-based purchasing plans by .56 of a  
376.14 percentage point for contracts beginning January 1, 2016, and ending December 31, 2017;  
376.15 and by .77 of a percentage point for contracts beginning January 1, 2018, and ending  
376.16 December 31, 2019. To meet the administrative reductions under this paragraph, the  
376.17 commissioner may reduce or eliminate administrative requirements, exclude additional  
376.18 unallowable administrative expenses identified under this section and resulting from the  
376.19 financial audits conducted under subdivision 9d, and utilize competitive bidding to gain  
376.20 efficiencies through economies of scale from increased enrollment. If the total reduction  
376.21 cannot be achieved through administrative reduction, the commissioner may limit total  
376.22 rate increases on payments to managed care plans and county-based purchasing plans.

376.23 Sec. 36. Minnesota Statutes 2014, section 256B.69, subdivision 9c, is amended to read:

376.24 Subd. 9c. **Managed care financial reporting.** (a) The commissioner shall collect  
376.25 detailed data regarding financials, provider payments, provider rate methodologies, and  
376.26 other data as determined by the commissioner. The commissioner, in consultation with the  
376.27 commissioners of health and commerce, and in consultation with managed care plans and  
376.28 county-based purchasing plans, shall set uniform criteria, definitions, and standards for the  
376.29 data to be submitted, and shall require managed care and county-based purchasing plans  
376.30 to comply with these criteria, definitions, and standards when submitting data under this  
376.31 section. In carrying out the responsibilities of this subdivision, the commissioner shall  
376.32 ensure that the data collection is implemented in an integrated and coordinated manner  
376.33 that avoids unnecessary duplication of effort. To the extent possible, the commissioner  
376.34 shall use existing data sources and streamline data collection in order to reduce public



377.1 and private sector administrative costs. Nothing in this subdivision shall allow release of  
377.2 information that is nonpublic data pursuant to section 13.02.

377.3 (b) Effective January 1, 2014, each managed care and county-based purchasing plan  
377.4 must quarterly provide to the commissioner the following information on state public  
377.5 programs, in the form and manner specified by the commissioner, according to guidelines  
377.6 developed by the commissioner in consultation with managed care plans and county-based  
377.7 purchasing plans under contract:

377.8 (1) an income statement by program;

377.9 (2) financial statement footnotes;

377.10 (3) quarterly profitability by program and population group;

377.11 (4) a medical liability summary by program and population group;

377.12 (5) received but unpaid claims report by program;

377.13 (6) services versus payment lags by program for hospital services, outpatient  
377.14 services, physician services, other medical services, and pharmaceutical benefits;

377.15 (7) utilization reports that summarize utilization and unit cost information by  
377.16 program for hospitalization services, outpatient services, physician services, and other  
377.17 medical services;

377.18 (8) pharmaceutical statistics by program and population group for measures of price  
377.19 and utilization of pharmaceutical services;

377.20 (9) subcapitation expenses by population group;

377.21 (10) third-party payments by program;

377.22 (11) all new, active, and closed subrogation cases by program;

377.23 (12) all new, active, and closed fraud and abuse cases by program;

377.24 (13) medical loss ratios by program;

377.25 (14) administrative expenses by category and subcategory by program that reconcile  
377.26 to other state and federal regulatory agencies;

377.27 (15) revenues by program, including investment income;

377.28 (16) nonadministrative service payments, provider payments, and reimbursement  
377.29 rates by provider type or service category, by program, paid by the managed care plan  
377.30 under this section or the county-based purchasing plan under section 256B.692 to  
377.31 providers and vendors for administrative services under contract with the plan, including  
377.32 but not limited to:

377.33 (i) individual-level provider payment and reimbursement rate data;

377.34 (ii) provider reimbursement rate methodologies by provider type, by program,  
377.35 including a description of alternative payment arrangements and payments outside the  
377.36 claims process;

378.1 (iii) data on implementation of legislatively mandated provider rate changes; and  
 378.2 (iv) individual-level provider payment and reimbursement rate data and plan-specific  
 378.3 provider reimbursement rate methodologies by provider type, by program, including  
 378.4 alternative payment arrangements and payments outside the claims process, provided to  
 378.5 the commissioner under this subdivision are nonpublic data as defined in section 13.02;  
 378.6 (17) data on the amount of reinsurance or transfer of risk by program; and  
 378.7 (18) contribution to reserve, by program.

378.8 (c) In the event a report is published or released based on data provided under  
 378.9 this subdivision, the commissioner shall provide the report to managed care plans and  
 378.10 county-based purchasing plans 15 days prior to the publication or release of the report.  
 378.11 Managed care plans and county-based purchasing plans shall have 15 days to review the  
 378.12 report and provide comment to the commissioner.

378.13 The quarterly reports shall be submitted to the commissioner no later than 60 days after the  
 378.14 end of the previous quarter, except the fourth-quarter report, which shall be submitted by  
 378.15 April 1 of each year. The fourth-quarter report shall include audited financial statements,  
 378.16 parent company audited financial statements, an income statement reconciliation report,  
 378.17 and any other documentation necessary to reconcile the detailed reports to the audited  
 378.18 financial statements.

378.19 (d) Managed care plans and county-based purchasing plans shall certify to the  
 378.20 commissioner for the purpose of financial reporting for state public health care programs  
 378.21 under this subdivision that costs reported for state public health care programs include:

378.22 (1) only services covered under the state plan and waivers, and related allowable  
 378.23 administrative expenses; and

378.24 (2) the dollar value of unallowable and nonstate plan services, including both  
 378.25 medical and administrative expenditures, that have been excluded.

378.26 Sec. 37. Minnesota Statutes 2014, section 256B.69, subdivision 9d, is amended to read:

378.27 Subd. 9d. **Financial audit and quality assurance audits.** ~~(a) The legislative~~  
 378.28 ~~auditor shall contract with an audit firm to conduct a biennial independent third-party~~  
 378.29 ~~financial audit of the information required to be provided by managed care plans and~~  
 378.30 ~~county-based purchasing plans under subdivision 9c, paragraph (b). The audit shall be~~  
 378.31 ~~conducted in accordance with generally accepted government auditing standards issued~~  
 378.32 ~~by the United States Government Accountability Office. The contract with the audit~~  
 378.33 ~~firm shall be designed and administered so as to render the independent third-party audit~~  
 378.34 ~~eligible for a federal subsidy, if available. The contract shall require the audit to include~~  
 378.35 ~~a determination of compliance with the federal Medicaid rate certification process. The~~

379.1 ~~contract shall require the audit to determine if the administrative expenses and investment~~  
379.2 ~~income reported by the managed care plans and county-based purchasing plans are~~  
379.3 ~~compliant with state and federal law.~~

379.4 ~~(b) For purposes of this subdivision, "independent third party" means an audit firm~~  
379.5 ~~that is independent in accordance with government auditing standards issued by the United~~  
379.6 ~~States Government Accountability Office and licensed in accordance with chapter 326A.~~  
379.7 ~~An audit firm under contract to provide services in accordance with this subdivision must~~  
379.8 ~~not have provided services to a managed care plan or county-based purchasing plan during~~  
379.9 ~~the period for which the audit is being conducted.~~

379.10 ~~(e) (a)~~ The commissioner shall require, in the request for bids and resulting contracts  
379.11 with managed care plans and county-based purchasing plans under this section and  
379.12 section 256B.692, that each managed care plan and county-based purchasing plan submit  
379.13 to and fully cooperate with the independent third-party financial ~~audit~~ audits by the  
379.14 legislative auditor under subdivision 9e of the information required under subdivision 9c,  
379.15 paragraph (b). Each contract with a managed care plan or county-based purchasing plan  
379.16 under this section or section 256B.692 must provide the commissioner and the ~~audit firm~~  
379.17 vendors contracting with the legislative auditor access to all data required to complete  
379.18 ~~the audit. For purposes of this subdivision, the contracting audit firm shall have the same~~  
379.19 ~~investigative power as the legislative auditor under section 3.978, subdivision 2~~ audits  
379.20 under subdivision 9e.

379.21 ~~(d) (b)~~ Each managed care plan and county-based purchasing plan providing services  
379.22 under this section shall provide to the commissioner biweekly encounter data and claims  
379.23 data for state public health care programs and shall participate in a quality assurance  
379.24 program that verifies the timeliness, completeness, accuracy, and consistency of the data  
379.25 provided. The commissioner shall develop written protocols for the quality assurance  
379.26 program and shall make the protocols publicly available. The commissioner shall contract  
379.27 for an independent third-party audit to evaluate the quality assurance protocols as to  
379.28 the capacity of the protocols to ensure complete and accurate data and to evaluate the  
379.29 commissioner's implementation of the protocols. ~~The audit firm under contract to provide~~  
379.30 ~~this evaluation must meet the requirements in paragraph (b).~~

379.31 ~~(e) Upon completion of the audit under paragraph (a) and receipt by the legislative~~  
379.32 ~~auditor, the legislative auditor shall provide copies of the audit report to the commissioner,~~  
379.33 ~~the state auditor, the attorney general, and the chairs and ranking minority members of the~~  
379.34 ~~health and human services finance committees of the legislature.~~ (c) Upon completion  
379.35 of the evaluation under paragraph (d) ~~(b)~~, the commissioner shall provide copies of the  
379.36 report to the legislative auditor and the chairs and ranking minority members of the health

380.1 ~~finance committees of the legislature~~ legislative committees with jurisdiction over health  
 380.2 care policy and financing.

380.3 ~~(f)~~ (d) Any actuary under contract with the commissioner to provide actuarial  
 380.4 services must meet the independence requirements under the professional code for fellows  
 380.5 in the Society of Actuaries and must not have provided actuarial services to a managed  
 380.6 care plan or county-based purchasing plan that is under contract with the commissioner  
 380.7 pursuant to this section and section 256B.692 during the period in which the actuarial  
 380.8 services are being provided. An actuary or actuarial firm meeting the requirements  
 380.9 of this paragraph must certify and attest to the rates paid to the managed care plans  
 380.10 and county-based purchasing plans under this section and section 256B.692, and the  
 380.11 certification and attestation must be auditable.

380.12 (e) The commissioner may conduct ad hoc audits of the state public health care  
 380.13 programs administrative and medical expenses of managed care plans and county-based  
 380.14 purchasing plans. This includes: financial and encounter data reported to the commissioner  
 380.15 under subdivision 9c, including payments to providers and subcontractors; supporting  
 380.16 documentation for expenditures; categorization of administrative and medical expenses;  
 380.17 and allocation methods used to attribute administrative expenses to state public health  
 380.18 care programs. These audits also must monitor compliance with data and financial  
 380.19 certifications provided to the commissioner for the purposes of managed care capitation  
 380.20 payment rate-setting. The managed care plans and county-based purchasing plans shall  
 380.21 fully cooperate with the audits in this subdivision.

380.22 ~~(g)~~ (f) Nothing in this subdivision shall allow the release of information that is  
 380.23 nonpublic data pursuant to section 13.02.

380.24 Sec. 38. Minnesota Statutes 2014, section 256B.69, is amended by adding a  
 380.25 subdivision to read:

380.26 Subd. 9e. **Financial audits.** (a) The legislative auditor shall contract with vendors  
 380.27 to conduct independent third-party financial audits of the information required to be  
 380.28 provided by managed care plans and county-based purchasing plans under subdivision  
 380.29 9c, paragraph (b). The audits by the vendors shall be conducted as vendor resources  
 380.30 permit and in accordance with generally accepted government auditing standards issued  
 380.31 by the United States Government Accountability Office. The contract with the vendors  
 380.32 shall be designed and administered so as to render the independent third-party audits  
 380.33 eligible for a federal subsidy, if available. The contract shall require the audits to include a  
 380.34 determination of compliance with the federal Medicaid rate certification process.

381.1 (b) For purposes of this subdivision, "independent third-party" means a vendor that  
381.2 is independent in accordance with government auditing standards issued by the United  
381.3 States Government Accountability Office.

381.4 Sec. 39. **[256B.695] DENTAL SERVICES UTILIZATION MEASURES.**

381.5 Subdivision 1. **Access benchmarks.** The commissioner shall evaluate access to  
381.6 dental services for children and adults enrolled in medical assistance and MinnesotaCare  
381.7 using the following measurements:

381.8 (1) the percentage of enrollees that have access to nonspecialty dental services within  
381.9 a 60-minute or 60-mile radius of the enrollee's residence through an analysis of utilization  
381.10 data from claims submitted to determine the service location, and by other appropriate  
381.11 means. This measurement shall be determined in the aggregate and by each individual  
381.12 payer, including the state and each managed care plan and county-based purchasing plan;

381.13 (2) the percentage of adult enrollees continuously enrolled for at least six months in  
381.14 a calendar year receiving an oral health evaluation within the year measured; and

381.15 (3) the percentage of children under the age of 21 continuously enrolled for at least  
381.16 90 days in a calendar year receiving, within the year measured:

381.17 (i) an oral health evaluation and sealants; and

381.18 (ii) follow-up care after an oral health evaluation.

381.19 Subd. 2. **Baseline measurement.** The commissioner shall establish a baseline  
381.20 measurement on access to dental services using the measures in subdivision 1 for enrollees  
381.21 receiving dental services through the fee-for-service system and through managed care  
381.22 plans or county-based purchasing plans. The baseline shall be calculated using calendar  
381.23 year 2014 as the base year.

381.24 Subd. 3. **Access improvement goals.** (a) By April 1, 2017, the commissioner  
381.25 shall calculate the measures described in subdivision 1 using fiscal year 2016, compare  
381.26 these measures with the baseline measures calculated under subdivision 2, and submit  
381.27 to the legislature the comparison results.

381.28 (b) If each measure described in subdivision 1, clauses (1), (2), and (3), has not  
381.29 increased by at least 20 percent, the dental competitive bidding system described in  
381.30 subdivision 4 shall be implemented by the commissioner if the legislature, by law, ratifies  
381.31 its implementation after receipt of the calculations described in paragraph (a).

381.32 Subd. 4. **Dental competitive bidding system.** (a) Effective for dental services  
381.33 rendered on or after January 1, 2019, the commissioner shall contract through a  
381.34 competitive bidding process with a qualified entity or entities to directly administer  
381.35 the delivery of dental services to all state public health care program enrollees. The

382.1 contracting entity or entities shall administer all dental services currently provided through  
 382.2 the fee-for-service system, managed care plans, and county-based purchasing plans.

382.3 (b) The commissioner may contract with a health care delivery system established  
 382.4 under section 256B.0755 or 256B.0756, or a county-based purchasing plan to receive  
 382.5 payment on a prospective per capita basis or through an alternative mutually agreed to  
 382.6 arrangement. The payment must be based on activities and outcomes directly related  
 382.7 to recruitment of dentists and outreach to state public health care program enrollees  
 382.8 residing within a designated geographic area. The contracted activities must be done in  
 382.9 coordination with the contracted administrator under paragraph (a) and the commissioner.  
 382.10 The commissioner shall contract with one entity under this paragraph to perform these  
 382.11 services within any designated geographic area.

382.12 Sec. 40. Minnesota Statutes 2014, section 256B.75, is amended to read:

382.13 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

382.14 (a) For outpatient hospital facility fee payments for services rendered on or after  
 382.15 October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted  
 382.16 charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those  
 382.17 services for which there is a federal maximum allowable payment. Effective for services  
 382.18 rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital  
 382.19 facility fees and emergency room facility fees shall be increased by eight percent over the  
 382.20 rates in effect on December 31, 1999, except for those services for which there is a federal  
 382.21 maximum allowable payment. Services for which there is a federal maximum allowable  
 382.22 payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum  
 382.23 allowable payment. Total aggregate payment for outpatient hospital facility fee services  
 382.24 shall not exceed the Medicare upper limit. If it is determined that a provision of this  
 382.25 section conflicts with existing or future requirements of the United States government with  
 382.26 respect to federal financial participation in medical assistance, the federal requirements  
 382.27 prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to  
 382.28 avoid reduced federal financial participation resulting from rates that are in excess of  
 382.29 the Medicare upper limitations.

382.30 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and  
 382.31 ambulatory surgery hospital facility fee services for critical access hospitals designated  
 382.32 under section 144.1483, clause (9), shall be paid on a cost-based payment system that is  
 382.33 based on the cost-finding methods and allowable costs of the Medicare program. Effective  
 382.34 for services provided on or after July 1, 2015, rates established for critical access hospitals

383.1 under this paragraph for the applicable payment year shall be the final payment and shall  
383.2 not be settled to actual costs.

383.3 (c) Effective for services provided on or after July 1, 2003, rates that are based  
383.4 on the Medicare outpatient prospective payment system shall be replaced by a budget  
383.5 neutral prospective payment system that is derived using medical assistance data. The  
383.6 commissioner shall provide a proposal to the 2003 legislature to define and implement  
383.7 this provision.

383.8 (d) For fee-for-service services provided on or after July 1, 2002, the total payment,  
383.9 before third-party liability and spenddown, made to hospitals for outpatient hospital  
383.10 facility services is reduced by .5 percent from the current statutory rate.

383.11 (e) In addition to the reduction in paragraph (d), the total payment for fee-for-service  
383.12 services provided on or after July 1, 2003, made to hospitals for outpatient hospital  
383.13 facility services before third-party liability and spenddown, is reduced five percent from  
383.14 the current statutory rates. Facilities defined under section 256.969, subdivision 16, are  
383.15 excluded from this paragraph.

383.16 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for  
383.17 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient  
383.18 hospital facility services before third-party liability and spenddown, is reduced three  
383.19 percent from the current statutory rates. Mental health services and facilities defined under  
383.20 section 256.969, subdivision 16, are excluded from this paragraph.

383.21 Sec. 41. Minnesota Statutes 2014, section 256B.76, subdivision 2, is amended to read:

383.22 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after  
383.23 October 1, 1992, the commissioner shall make payments for dental services as follows:

383.24 (1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25  
383.25 percent above the rate in effect on June 30, 1992; and

383.26 (2) dental rates shall be converted from the 50th percentile of 1982 to the 50th  
383.27 percentile of 1989, less the percent in aggregate necessary to equal the above increases.

383.28 (b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments  
383.29 shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

383.30 (c) Effective for services rendered on or after January 1, 2000, payment rates for  
383.31 dental services shall be increased by three percent over the rates in effect on December  
383.32 31, 1999.

383.33 (d) Effective for services provided on or after January 1, 2002, payment for  
383.34 diagnostic examinations and dental x-rays provided to children under age 21 shall be the  
383.35 lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

384.1 (e) The increases listed in paragraphs (b) and (c) shall be implemented January 1,  
384.2 2000, for managed care.

384.3 (f) Effective for dental services rendered on or after October 1, 2010, by a  
384.4 state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based  
384.5 on the Medicare principles of reimbursement. This payment shall be effective for services  
384.6 rendered on or after January 1, 2011, to recipients enrolled in managed care plans or  
384.7 county-based purchasing plans.

384.8 (g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics  
384.9 in paragraph (f), including state and federal shares, are less than \$1,850,000 per fiscal  
384.10 year, a supplemental state payment equal to the difference between the total payments  
384.11 in paragraph (f) and \$1,850,000 shall be paid from the general fund to state-operated  
384.12 services for the operation of the dental clinics.

384.13 ~~(h) If the cost-based payment system for state-operated dental clinics described in~~  
384.14 ~~paragraph (f) does not receive federal approval, then state-operated dental clinics shall be~~  
384.15 ~~designated as critical access dental providers under subdivision 4, paragraph (b), and shall~~  
384.16 ~~receive the critical access dental reimbursement rate as described under subdivision 4,~~  
384.17 ~~paragraph (a).~~

384.18 ~~(h)~~ (h) Effective for services rendered on or after September 1, 2011, through June  
384.19 30, 2013, payment rates for dental services shall be reduced by three percent. This  
384.20 reduction does not apply to state-operated dental clinics in paragraph (f).

384.21 ~~(i)~~ (i) Effective for services rendered on or after January 1, 2014, payment rates for  
384.22 dental services shall be increased by five percent from the rates in effect on December  
384.23 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f),  
384.24 federally qualified health centers, rural health centers, and Indian health services. Effective  
384.25 January 1, 2014, payments made to managed care plans and county-based purchasing  
384.26 plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase  
384.27 described in this paragraph.

384.28 (j) Effective for services rendered on or after July 1, 2015, payment rates for dental  
384.29 services shall be set to the percentage of 2012 fee-for-service submitted charges that  
384.30 results in a 24 percent increase in the aggregate payment for dental services from the rates  
384.31 in effect on June 30, 2015. Effective January 1, 2016, payments made to managed care  
384.32 plans and county-based purchasing plans shall reflect the payment increase described in  
384.33 this paragraph.

384.34 Sec. 42. Minnesota Statutes 2014, section 256B.76, subdivision 4, is amended to read:



385.1 Subd. 4. **Critical access dental providers.** ~~(a) Effective for dental services~~  
 385.2 ~~rendered on or after January 1, 2002, the commissioner shall increase reimbursements~~  
 385.3 ~~to dentists and dental clinics deemed by the commissioner to be critical access dental~~  
 385.4 ~~providers. For dental services rendered on or after July 1, 2007, the commissioner shall~~  
 385.5 ~~increase reimbursement by 35 percent above the reimbursement rate that would otherwise~~  
 385.6 ~~be paid to the critical access dental provider. The commissioner shall pay the managed~~  
 385.7 ~~care plans and county-based purchasing plans in amounts sufficient to reflect increased~~  
 385.8 ~~reimbursements to critical access dental providers as approved by the commissioner.~~  
 385.9 Effective July 1, 2015, the commissioner shall administer an incentive program that makes  
 385.10 payments to dental clinics that meet the following eligibility criteria:

385.11 (1) nonspecialty dental clinics must meet or exceed the annual median ratio of  
 385.12 restorative to preventive dental services calculated based on the median ratio of all  
 385.13 nonspecialty dental clinics serving public health care program enrollees; and

385.14 (2) specialty dental clinics must have provided services to a fee-for-service or  
 385.15 managed care enrollee during the prior year, and must meet or exceed the annual median  
 385.16 of dental providers for that dental specialty serving public health care program enrollees.

385.17 ~~(b) The commissioner shall designate the following dentists and dental clinics as~~  
 385.18 ~~critical access dental providers:~~

385.19 ~~(1) nonprofit community clinics that:~~

385.20 ~~(i) have nonprofit status in accordance with chapter 317A;~~

385.21 ~~(ii) have tax exempt status in accordance with the Internal Revenue Code, section~~  
 385.22 ~~501(c)(3);~~

385.23 ~~(iii) are established to provide oral health services to patients who are low income,~~  
 385.24 ~~uninsured, have special needs, and are underserved;~~

385.25 ~~(iv) have professional staff familiar with the cultural background of the clinic's~~  
 385.26 ~~patients;~~

385.27 ~~(v) charge for services on a sliding fee scale designed to provide assistance to~~  
 385.28 ~~low-income patients based on current poverty income guidelines and family size;~~

385.29 ~~(vi) do not restrict access or services because of a patient's financial limitations~~  
 385.30 ~~or public assistance status; and~~

385.31 ~~(vii) have free care available as needed;~~

385.32 ~~(2) federally qualified health centers, rural health clinics, and public health clinics;~~

385.33 ~~(3) city or county owned and operated hospital-based dental clinics;~~

385.34 ~~(4) a dental clinic or dental group owned and operated by a nonprofit corporation in~~  
 385.35 ~~accordance with chapter 317A with more than 10,000 patient encounters per year with~~  
 385.36 ~~patients who are uninsured or covered by medical assistance or MinnesotaCare;~~

386.1 ~~(5) a dental clinic owned and operated by the University of Minnesota or the~~  
386.2 ~~Minnesota State Colleges and Universities system; and~~

386.3 ~~(6) private practicing dentists if:~~

386.4 ~~(i) the dentist's office is located within a health professional shortage area as defined~~  
386.5 ~~under Code of Federal Regulations, title 42, part 5, and United States Code, title 42,~~  
386.6 ~~section 254E;~~

386.7 ~~(ii) more than 50 percent of the dentist's patient encounters per year are with patients~~  
386.8 ~~who are uninsured or covered by medical assistance or MinnesotaCare;~~

386.9 ~~(iii) the dentist does not restrict access or services because of a patient's financial~~  
386.10 ~~limitations or public assistance status; and~~

386.11 ~~(iv) the level of service provided by the dentist is critical to maintaining adequate~~  
386.12 ~~levels of patient access within the service area in which the dentist operates.~~

386.13 ~~(e) A designated critical access clinic shall receive the reimbursement rate specified~~  
386.14 ~~in paragraph (a) for dental services provided off site at a private dental office if the~~  
386.15 ~~following requirements are met:~~

386.16 ~~(1) the designated critical access dental clinic is located within a health professional~~  
386.17 ~~shortage area as defined under Code of Federal Regulations, title 42, part 5, and United~~  
386.18 ~~States Code, title 42, section 254E, and is located outside the seven-county metropolitan~~  
386.19 ~~area;~~

386.20 ~~(2) the designated critical access dental clinic is not able to provide the service~~  
386.21 ~~and refers the patient to the off-site dentist;~~

386.22 ~~(3) the service, if provided at the critical access dental clinic, would be reimbursed~~  
386.23 ~~at the critical access reimbursement rate;~~

386.24 ~~(4) the dentist and allied dental professionals providing the services off site are~~  
386.25 ~~licensed and in good standing under chapter 150A;~~

386.26 ~~(5) the dentist providing the services is enrolled as a medical assistance provider;~~

386.27 ~~(6) the critical access dental clinic submits the claim for services provided off site~~  
386.28 ~~and receives the payment for the services; and~~

386.29 ~~(7) the critical access dental clinic maintains dental records for each claim submitted~~  
386.30 ~~under this paragraph, including the name of the dentist, the off-site location, and the license~~  
386.31 ~~number of the dentist and allied dental professionals providing the services. Eighty percent~~  
386.32 ~~of the total payments made under this subdivision shall be paid to nonspecialty dental~~  
386.33 ~~clinics and 20 percent of the total payments paid shall be paid to specialty dental clinics.~~

386.34 ~~(c) For fiscal year 2016, the total payments under paragraph (a) shall not exceed the~~  
386.35 ~~total amount paid under the critical access dental program in fiscal year 2015. For fiscal~~  
386.36 ~~year 2017 and each fiscal year thereafter, total payments under paragraph (a) shall be~~

387.1 adjusted annually based on the value of the dental services component of the medical care  
387.2 services expenditure category of the Consumer Price Index for all Urban Consumers  
387.3 (CPI-U): U.S. city average from the previous year.

387.4 (d) Payments under paragraph (a) shall be made proportionate to the dental clinic's  
387.5 share of enrollees served in both managed care and fee-for-service.

387.6 (e) Payments under paragraph (a) shall be calculated based on the prior fiscal year  
387.7 claims submitted and be prorated based on the number of months the dental clinic was  
387.8 enrolled in any fee-for-service or managed care program. Payments to dental clinics under  
387.9 this subdivision shall be made no later than April 1 of the year following the fiscal year  
387.10 for which payments are owed beginning fiscal year 2016.

387.11 (f) To be eligible for payments under this subdivision, a dental clinic must provide  
387.12 dental services to medical assistance and MinnesotaCare enrollees.

387.13 (g) No payments under this subdivision shall be made to dental clinics that receive  
387.14 a cost-based rate, including, but not limited to, federally qualified health centers and  
387.15 state-operated dental clinics.

387.16 Sec. 43. Minnesota Statutes 2014, section 256B.76, subdivision 7, is amended to read:

387.17 **Subd. 7. Payment for certain primary care services and immunization**  
387.18 **administration.** (a) Payment for certain primary care services and immunization  
387.19 administration services rendered on or after January 1, 2013, through December 31, 2014,  
387.20 shall be made in accordance with section 1902(a)(13) of the Social Security Act.

387.21 (b) Effective for primary care services provided on or after July 1, 2015, payment  
387.22 rates shall be increased by one percent over the rates in effect on June 30, 2015. Effective  
387.23 January 1, 2016, payments made to managed care plans and county-based purchasing  
387.24 plans shall reflect the payment increase described in this paragraph.

387.25 (c) Effective for services provided on or after November 1, 2017, payment rates  
387.26 shall be increased 0.25 percent over the rates in effect October 31, 2017. Effective January  
387.27 1, 2018, payments made to managed care plans and county-based purchasing plans shall  
387.28 reflect the payment increase described in this paragraph.

387.29 (d) For purposes of paragraphs (b) and (c), primary care services shall include  
387.30 preventive medicine visits or family planning visits when billed by a physician, advanced  
387.31 registered nurse practitioner, or physician assistant practicing in a family planning agency,  
387.32 general internal medicine practice, general pediatric practice, general geriatric practice, or  
387.33 family medicine practice.

388.1 Sec. 44. Minnesota Statutes 2014, section 256B.767, is amended to read:

388.2 **256B.767 MEDICARE PAYMENT LIMIT.**

388.3 (a) Effective for services rendered on or after July 1, 2010, fee-for-service payment  
388.4 rates for physician and professional services under section 256B.76, subdivision 1, and  
388.5 basic care services subject to the rate reduction specified in section 256B.766, shall not  
388.6 exceed the Medicare payment rate for the applicable service, as adjusted for any changes  
388.7 in Medicare payment rates after July 1, 2010. The commissioner shall implement this  
388.8 section after any other rate adjustment that is effective July 1, 2010, and shall reduce rates  
388.9 under this section by first reducing or eliminating provider rate add-ons.

388.10 (b) This section does not apply to services provided by advanced practice certified  
388.11 nurse midwives licensed under chapter 148 or traditional midwives licensed under chapter  
388.12 147D. Notwithstanding this exemption, medical assistance fee-for-service payment rates  
388.13 for advanced practice certified nurse midwives and licensed traditional midwives shall  
388.14 equal and shall not exceed the medical assistance payment rate to physicians for the  
388.15 applicable service.

388.16 (c) This section does not apply to mental health services or physician services billed  
388.17 by a psychiatrist or an advanced practice registered nurse with a specialty in mental health.

388.18 (d) Effective for durable medical equipment, prosthetics, orthotics, or supplies  
388.19 provided on or after July 1, 2013, ~~through June 30, 2015~~, 2015, the payment rate for items  
388.20 that are subject to the rates established under Medicare's National Competitive Bidding  
388.21 Program shall be equal to the rate that applies to the same item when not subject to the  
388.22 rate established under Medicare's National Competitive Bidding Program. This paragraph  
388.23 does not apply to mail-order diabetic supplies and does not apply to items provided to  
388.24 dually eligible recipients when Medicare is the primary payer of the item.

388.25 Sec. 45. **256B.79] INTEGRATED CARE FOR HIGH-RISK PREGNANT**  
388.26 **WOMEN.**

388.27 Subdivision 1. Definitions. (a) For purposes of this section, the following terms  
388.28 have the meanings given them.

388.29 (b) "Adverse outcomes" means maternal opiate addiction, other reportable prenatal  
388.30 substance abuse, low birth weight, or preterm birth.

388.31 (c) "Qualified integrated perinatal care collaborative" or "collaborative" means  
388.32 a combination of (1) members of community-based organizations that represent  
388.33 communities within the identified targeted populations, and (2) local or tribally based  
388.34 service entities, including health care, public health, social services, mental health,  
388.35 chemical dependency treatment, and community-based providers, determined by the

389.1 commissioner to meet the criteria for the provision of integrated care and enhanced  
389.2 services for enrollees within targeted populations.

389.3 (d) "Targeted populations" means pregnant medical assistance enrollees residing  
389.4 in geographic areas identified by the commissioner as being at above-average risk for  
389.5 adverse outcomes.

389.6 Subd. 2. **Pilot program established.** The commissioner shall implement a pilot  
389.7 program to improve birth outcomes and strengthen early parental resilience for pregnant  
389.8 women who are medical assistance enrollees, are at significantly elevated risk for adverse  
389.9 outcomes of pregnancy, and are in targeted populations. The program must promote the  
389.10 provision of integrated care and enhanced services to these pregnant women, including  
389.11 postpartum coordination to ensure ongoing continuity of care, by qualified integrated  
389.12 perinatal care collaboratives.

389.13 Subd. 3. **Grant awards.** The commissioner shall award grants to qualifying  
389.14 applicants to support interdisciplinary, integrated perinatal care. Grants must be awarded  
389.15 beginning July 1, 2016. Grant funds must be distributed through a request for proposals  
389.16 process to a designated lead agency within an entity that has been determined to be a  
389.17 qualified integrated perinatal care collaborative or within an entity in the process of  
389.18 meeting the qualifications to become a qualified integrated perinatal care collaborative.  
389.19 Grant awards must be used to support interdisciplinary, team-based needs assessments,  
389.20 planning, and implementation of integrated care and enhanced services for targeted  
389.21 populations. In determining grant award amounts, the commissioner shall consider the  
389.22 identified health and social risks linked to adverse outcomes and attributed to enrollees  
389.23 within the identified targeted population.

389.24 Subd. 4. **Eligibility for grants.** To be eligible for a grant under this section, an  
389.25 entity must show that the entity meets or is in the process of meeting qualifications  
389.26 established by the commissioner to be a qualified integrated perinatal care collaborative.  
389.27 These qualifications must include evidence that the entity has or is in the process of  
389.28 developing policies, services, and partnerships to support interdisciplinary, integrated care.  
389.29 The policies, services, and partnerships must meet specific criteria and be approved by the  
389.30 commissioner. The commissioner shall establish a process to review the collaborative's  
389.31 capacity for interdisciplinary, integrated care, to be reviewed at the commissioner's  
389.32 discretion. In determining whether the entity meets the qualifications for a qualified  
389.33 integrated perinatal care collaborative, the commissioner shall verify and review whether  
389.34 the entity's policies, services, and partnerships:

389.35 (1) optimize early identification of drug and alcohol dependency and abuse during  
389.36 pregnancy, effectively coordinate referrals and follow-up of identified patients to

390.1 evidence-based or evidence-informed treatment, and integrate perinatal care services with  
390.2 behavioral health and substance abuse services;

390.3 (2) enhance access to, and effective use of, needed health care or tribal health care  
390.4 services, public health or tribal public health services, social services, mental health  
390.5 services, chemical dependency services, or services provided by community-based  
390.6 providers by bridging cultural gaps within systems of care and by integrating  
390.7 community-based paraprofessionals such as doulas and community health workers as  
390.8 routinely available service components;

390.9 (3) encourage patient education about prenatal care, birthing, and postpartum  
390.10 care, and document how patient education is provided. Patient education may include  
390.11 information on nutrition, reproductive life planning, breastfeeding, and parenting;

390.12 (4) integrate child welfare case planning with substance abuse treatment planning  
390.13 and monitoring, as appropriate;

390.14 (5) effectively systematize screening, collaborative care planning, referrals, and  
390.15 follow up for behavioral and social risks known to be associated with adverse outcomes  
390.16 and known to be prevalent within the targeted populations;

390.17 (6) facilitate ongoing continuity of care to include postpartum coordination and  
390.18 referrals for interconception care, continued treatment for substance abuse, identification  
390.19 and referrals for maternal depression and other chronic mental health conditions,  
390.20 continued medication management for chronic diseases, and appropriate referrals to tribal  
390.21 or county-based social services agencies and tribal or county-based public health nursing  
390.22 services; and

390.23 (7) implement ongoing quality improvement activities as determined by the  
390.24 commissioner, including collection and use of data from qualified providers on metrics  
390.25 of quality such as health outcomes and processes of care, and the use of other data that  
390.26 has been collected by the commissioner.

390.27 Subd. 5. **Gaps in communication, support, and care.** A collaborative receiving  
390.28 a grant under this section must develop means of identifying and reporting gaps in the  
390.29 collaborative's communication, administrative support, and direct care that must be  
390.30 remedied for the collaborative to effectively provide integrated care and enhanced services  
390.31 to targeted populations.

390.32 Subd. 6. **Report.** By January 31, 2019, the commissioner shall report to the chairs  
390.33 and ranking minority members of the legislative committees with jurisdiction over health  
390.34 and human services policy and finance on the status and progress of the pilot program.

390.35 The report must:

390.36 (1) describe the capacity of collaboratives receiving grants under this section;

- 391.1 (2) contain aggregate information about enrollees served within targeted populations;  
 391.2 (3) describe the utilization of enhanced prenatal services;  
 391.3 (4) for enrollees identified with maternal substance use disorders, describe the  
 391.4 utilization of substance use treatment and dispositions of any child protection cases;  
 391.5 (5) contain data on outcomes within targeted populations and compare these  
 391.6 outcomes to outcomes statewide, using standard categories of race and ethnicity; and  
 391.7 (6) include recommendations for continuing the program or sustaining improvements  
 391.8 through other means beyond June 30, 2019.

391.9 Subd. 7. **Expiration.** This section expires June 30, 2019.

391.10 Sec. 46. Minnesota Statutes 2014, section 256L.01, subdivision 3a, is amended to read:

391.11 Subd. 3a. **Family.** (a) Except as provided in paragraphs (c) and (d), "family" has  
 391.12 the meaning given for family and family size as defined in Code of Federal Regulations,  
 391.13 title 26, section 1.36B-1.

391.14 (b) The term includes children who are temporarily absent from the household in  
 391.15 settings such as schools, camps, or parenting time with noncustodial parents.

391.16 (c) For an individual who does not expect to file a federal tax return and does not  
 391.17 expect to be claimed as a dependent for the applicable tax year, "family" has the meaning  
 391.18 given in Code of Federal Regulations, title 42, section 435.603(f)(3).

391.19 (d) For a married couple, "family" has the meaning given in Code of Federal  
 391.20 Regulations, title 42, section 435.603(f)(4).

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

391.22 Sec. 47. Minnesota Statutes 2014, section 256L.01, subdivision 5, is amended to read:

391.23 Subd. 5. **Income.** "Income" has the meaning given for modified adjusted gross  
 391.24 income, as defined in Code of Federal Regulations, title 26, section 1.36B-1-, and means a  
 391.25 household's projected annual income for the applicable tax year

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

391.27 Sec. 48. Minnesota Statutes 2014, section 256L.03, subdivision 5, is amended to read:

391.28 Subd. 5. **Cost-sharing.** (a) Except as otherwise provided in this subdivision, the  
 391.29 MinnesotaCare benefit plan shall include the following cost-sharing requirements for all  
 391.30 enrollees:

- 391.31 (1) \$3 per prescription for adult enrollees;  
 391.32 (2) \$25 for eyeglasses for adult enrollees;

392.1 (3) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an  
 392.2 episode of service which is required because of a recipient's symptoms, diagnosis, or  
 392.3 established illness, and which is delivered in an ambulatory setting by a physician or  
 392.4 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,  
 392.5 audiologist, optician, or optometrist;

392.6 (4) \$6 for nonemergency visits to a hospital-based emergency room for services  
 392.7 provided through December 31, 2010, and \$3.50 effective January 1, 2011; and

392.8 (5) a family deductible equal to ~~the maximum amount allowed under Code of~~  
 392.9 ~~Federal Regulations, title 42, part 447.54.~~ \$2.75 per month per family and adjusted  
 392.10 annually by the percentage increase in the medical care component of the CPI-U for  
 392.11 the period of September to September of the preceding calendar year, rounded to the  
 392.12 next-higher five cent increment.

392.13 (b) Paragraph (a) does not apply to children under the age of 21 and to American  
 392.14 Indians as defined in Code of Federal Regulations, title 42, section 447.51.

392.15 (c) Paragraph (a), clause (3), does not apply to mental health services.

392.16 (d) MinnesotaCare reimbursements to fee-for-service providers and payments to  
 392.17 managed care plans or county-based purchasing plans shall not be increased as a result of  
 392.18 the reduction of the co-payments in paragraph (a), clause (4), effective January 1, 2011.

392.19 (e) The commissioner, through the contracting process under section 256L.12,  
 392.20 may allow managed care plans and county-based purchasing plans to waive the family  
 392.21 deductible under paragraph (a), clause (5). The value of the family deductible shall not be  
 392.22 included in the capitation payment to managed care plans and county-based purchasing  
 392.23 plans. Managed care plans and county-based purchasing plans shall certify annually to the  
 392.24 commissioner the dollar value of the family deductible.

392.25 **EFFECTIVE DATE.** The amendment to paragraph (a), clause (5), is effective  
 392.26 retroactively from January 1, 2014. The amendment to paragraph (b) is effective the  
 392.27 day following final enactment.

392.28 Sec. 49. Minnesota Statutes 2014, section 256L.04, subdivision 1a, is amended to read:

392.29 Subd. 1a. **Social Security number required.** (a) Individuals and families applying  
 392.30 for MinnesotaCare coverage must provide a Social Security number if required in Code of  
 392.31 Federal Regulations, title 45, section 155.310(a)(3).

392.32 (b) ~~The commissioner shall not deny eligibility to an otherwise eligible applicant~~  
 392.33 ~~who has applied for a Social Security number and is awaiting issuance of that Social~~  
 392.34 ~~Security number.~~



393.1 ~~(e) Newborns enrolled under section 256L.05, subdivision 3, are exempt from the~~  
 393.2 ~~requirements of this subdivision.~~

393.3 ~~(d) Individuals who refuse to provide a Social Security number because of~~  
 393.4 ~~well-established religious objections are exempt from the requirements of this subdivision.~~  
 393.5 ~~The term "well-established religious objections" has the meaning given in Code of Federal~~  
 393.6 ~~Regulations, title 42, section 435.910.~~

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

393.8 Sec. 50. Minnesota Statutes 2014, section 256L.04, subdivision 1c, is amended to read:

393.9 Subd. 1c. **General requirements.** To be eligible for coverage under MinnesotaCare,  
 393.10 a person must meet the eligibility requirements of this section. A person eligible for  
 393.11 MinnesotaCare shall not be considered a qualified individual under section 1312 of the  
 393.12 Affordable Care Act, and is not eligible for enrollment in a qualified health plan offered  
 393.13 through MNsure under chapter 62V.

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

393.15 Sec. 51. Minnesota Statutes 2014, section 256L.04, subdivision 7b, is amended to read:

393.16 Subd. 7b. **Annual income limits adjustment.** The commissioner shall adjust the  
 393.17 income limits under this section each July 1 by the annual update of the federal poverty  
 393.18 guidelines following publication by the United States Department of Health and Human  
 393.19 Services except that the income standards shall not go below those in effect on July 1,  
 393.20 2009 annually on January 1 as provided in Code of Federal Regulations, title 26, section  
 393.21 1.36B-1(h).

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

393.23 Sec. 52. Minnesota Statutes 2014, section 256L.05, is amended by adding a subdivision  
 393.24 to read:

393.25 Subd. 2a. **Eligibility and coverage.** For purposes of this chapter, an individual  
 393.26 is eligible for MinnesotaCare following a determination by the commissioner that the  
 393.27 individual meets the eligibility criteria for the applicable period of eligibility. For an  
 393.28 individual required to pay a premium, coverage is only available in each month of the  
 393.29 applicable period of eligibility for which a premium is paid.

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

394.1 Sec. 53. Minnesota Statutes 2014, section 256L.05, subdivision 3, is amended to read:

394.2 Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the first  
 394.3 day of the month following the month in which eligibility is approved and the first premium  
 394.4 payment has been received. The effective date of coverage for new members added to the  
 394.5 family is the first day of the month following the month in which the change is reported. All  
 394.6 eligibility criteria must be met by the family at the time the new family member is added.  
 394.7 The income of the new family member is included with the family's modified adjusted gross  
 394.8 income and the adjusted premium begins in the month the new family member is added.

394.9 (b) The initial premium must be received by the last working day of the month for  
 394.10 coverage to begin the first day of the following month.

394.11 (c) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to  
 394.12 256L.18 are secondary to a plan of insurance or benefit program under which an eligible  
 394.13 person may have coverage and the commissioner shall use cost avoidance techniques to  
 394.14 ensure coordination of any other health coverage for eligible persons. The commissioner  
 394.15 shall identify eligible persons who may have coverage or benefits under other plans of  
 394.16 insurance or who become eligible for medical assistance.

394.17 (d) The effective date of coverage for individuals or families who are exempt from  
 394.18 paying premiums under section 256L.15, subdivision 1, paragraph (c), is the first day of  
 394.19 the month following the month in which ~~verification of American Indian status is received~~  
 394.20 ~~or~~ eligibility is approved, ~~whichever is later.~~

394.21 Sec. 54. Minnesota Statutes 2014, section 256L.05, subdivision 3a, is amended to read:

394.22 Subd. 3a. **Renewal Redetermination of eligibility.** (a) ~~Beginning July 1, 2007, An~~  
 394.23 ~~enrollee's eligibility must be renewed every 12 months~~ redetermined on an annual basis.  
 394.24 ~~The 12-month period begins in the month after the month the application is approved. The~~  
 394.25 period of eligibility is the entire calendar year following the year in which eligibility is  
 394.26 redetermined. Beginning in calendar year 2015, eligibility redeterminations shall occur  
 394.27 during the open enrollment period for qualified health plans as specified in Code of  
 394.28 Federal Regulations, title 45, section 155.410.

394.29 (b) Each new period of eligibility must take into account any changes in  
 394.30 circumstances that impact eligibility and premium amount. ~~An enrollee must provide all~~  
 394.31 ~~the information needed to redetermine eligibility by the first day of the month that ends~~  
 394.32 ~~the eligibility period. The premium for the new period of eligibility must be received~~  
 394.33 Coverage begins as provided in section 256L.06 ~~in order for eligibility to continue.~~

394.34 (c) ~~For children enrolled in MinnesotaCare, the first period of renewal begins the~~  
 394.35 ~~month the enrollee turns 21 years of age.~~

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

395.2 Sec. 55. Minnesota Statutes 2014, section 256L.05, subdivision 4, is amended to read:

395.3 Subd. 4. **Application processing.** The commissioner of human services shall  
395.4 determine an applicant's eligibility for MinnesotaCare no more than ~~30~~ 45 days from the  
395.5 date that the application is received by the Department of Human Services as set forth in  
395.6 Code of Federal Regulations, title 42, section 435.912. ~~Beginning January 1, 2000, this~~  
395.7 ~~requirement also applies to local county human services agencies that determine eligibility~~  
395.8 ~~for MinnesotaCare.~~

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

395.10 Sec. 56. Minnesota Statutes 2014, section 256L.06, subdivision 3, is amended to read:

395.11 Subd. 3. **Commissioner's duties and payment.** (a) Premiums are dedicated to the  
395.12 commissioner for MinnesotaCare.

395.13 (b) The commissioner shall develop and implement procedures to: (1) require  
395.14 enrollees to report changes in income; (2) adjust sliding scale premium payments, based  
395.15 upon both increases and decreases in enrollee income, at the time the change in income  
395.16 is reported; and (3) disenroll enrollees from MinnesotaCare for failure to pay required  
395.17 premiums. Failure to pay includes payment with a dishonored check, a returned automatic  
395.18 bank withdrawal, or a refused credit card or debit card payment. The commissioner may  
395.19 demand a guaranteed form of payment, including a cashier's check or a money order, as  
395.20 the only means to replace a dishonored, returned, or refused payment.

395.21 (c) Premiums are calculated on a calendar month basis and may be paid on a  
395.22 monthly, quarterly, or semiannual basis, with the first payment due upon notice from the  
395.23 commissioner of the premium amount required. The commissioner shall inform applicants  
395.24 and enrollees of these premium payment options. Premium payment is required before  
395.25 enrollment is complete and to maintain eligibility in MinnesotaCare. Premium payments  
395.26 received before noon are credited the same day. Premium payments received after noon  
395.27 are credited on the next working day.

395.28 (d) Nonpayment of the premium will result in disenrollment from the plan  
395.29 effective for the calendar month following the month for which the premium was due.  
395.30 ~~Persons disenrolled for nonpayment who pay all past due premiums as well as current~~  
395.31 ~~premiums due, including premiums due for the period of disenrollment, within 20 days of~~  
395.32 ~~disenrollment, shall be reenrolled retroactively to the first day of disenrollment may not~~  
395.33 reenroll prior to the first day of the month following the payment of an amount equal to  
395.34 two months' premiums.

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

396.2 Sec. 57. Minnesota Statutes 2014, section 256L.11, is amended by adding a subdivision  
396.3 to read:

396.4 **Subd. 7a. Dental providers.** Effective for dental services provided to  
396.5 MinnesotaCare enrollees on or after January 1, 2016, the payment rate shall be the rate  
396.6 described under section 256B.76, subdivision 2, paragraph (i).

396.7 Sec. 58. Minnesota Statutes 2014, section 256L.121, subdivision 1, is amended to read:

396.8 Subdivision 1. **Competitive process.** The commissioner of human services shall  
396.9 establish a competitive process for entering into contracts with participating entities for  
396.10 the offering of standard health plans through MinnesotaCare. Coverage through standard  
396.11 health plans must be available to enrollees beginning January 1, 2015. Each standard  
396.12 health plan must cover the health services listed in and meet the requirements of section  
396.13 256L.03. The competitive process must meet the requirements of section 1331 of the  
396.14 Affordable Care Act and be designed to ensure enrollee access to high-quality health care  
396.15 coverage options. The commissioner, to the extent feasible, shall seek to ensure that  
396.16 enrollees have a choice of coverage from more than one participating entity within a  
396.17 geographic area. In counties that were part of a county-based purchasing plan on January  
396.18 1, 2013, the commissioner shall use the medical assistance competitive procurement  
396.19 process under section 256B.69, ~~subdivisions 1 to 32,~~ under which selection of entities is  
396.20 based on criteria related to provider network access, coordination of health care with other  
396.21 local services, alignment with local public health goals, and other factors.

396.22 Sec. 59. Minnesota Statutes 2014, section 256L.15, subdivision 2, is amended to read:

396.23 Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The  
396.24 commissioner shall establish a sliding fee scale to determine the percentage of monthly  
396.25 individual or family income that households at different income levels must pay to obtain  
396.26 coverage through the MinnesotaCare program. The sliding fee scale must be based on the  
396.27 enrollee's monthly individual or family income.

396.28 (b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums  
396.29 according to the premium scale specified in paragraph (e) ~~with the exception that children~~  
396.30 ~~20 years of age and younger in families with income at or below 200 percent of the federal~~  
396.31 ~~poverty guidelines shall pay no premiums~~ (d).

396.32 (c) Paragraph (b) does not apply to:

396.33 (1) children 20 years of age or younger; and

397.1 (2) individuals with household incomes below 35 percent of the federal poverty  
 397.2 guidelines.

397.3 (e) (d) The following premium scale is established for each individual in the  
 397.4 household who is 21 years of age or older and enrolled in MinnesotaCare:

397.5 <b>Federal Poverty Guideline</b>		397.5 <b>Individual Premium</b>
397.6 <b>Greater than or Equal to</b>	397.6 <b>Less than</b>	397.6 <b>Amount</b>
397.7 <del>0%</del> <u>35%</u>	397.7 55%	397.7 \$4
397.8 55%	397.8 80%	397.8 \$6
397.9 80%	397.9 90%	397.9 \$8
397.10 90%	397.10 100%	397.10 \$10
397.11 100%	397.11 110%	397.11 \$12
397.12 110%	397.12 120%	397.12 <del>\$15</del> <u>\$14</u>
397.13 120%	397.13 130%	397.13 <del>\$18</del> <u>\$15</u>
397.14 130%	397.14 140%	397.14 <del>\$21</del> <u>\$16</u>
397.15 140%	397.15 150%	397.15 \$25
397.16 150%	397.16 160%	397.16 \$29
397.17 160%	397.17 170%	397.17 \$33
397.18 170%	397.18 180%	397.18 \$38
397.19 180%	397.19 190%	397.19 \$43
397.20 190%		397.20 \$50

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

397.22 Sec. 60. Minnesota Statutes 2014, section 297A.70, subdivision 7, is amended to read:

397.23 Subd. 7. **Hospitals, outpatient surgical centers, and critical access dental**

397.24 **providers.** (a) Sales, except for those listed in paragraph (d), to a hospital are exempt,  
 397.25 if the items purchased are used in providing hospital services. For purposes of this  
 397.26 subdivision, "hospital" means a hospital organized and operated for charitable purposes  
 397.27 within the meaning of section 501(c)(3) of the Internal Revenue Code, and licensed under  
 397.28 chapter 144 or by any other jurisdiction, and "hospital services" are services authorized or  
 397.29 required to be performed by a "hospital" under chapter 144.

397.30 (b) Sales, except for those listed in paragraph (d), to an outpatient surgical center  
 397.31 are exempt, if the items purchased are used in providing outpatient surgical services. For  
 397.32 purposes of this subdivision, "outpatient surgical center" means an outpatient surgical  
 397.33 center organized and operated for charitable purposes within the meaning of section  
 397.34 501(c)(3) of the Internal Revenue Code, and licensed under chapter 144 or by any other  
 397.35 jurisdiction. For the purposes of this subdivision, "outpatient surgical services" means:  
 397.36 (1) services authorized or required to be performed by an outpatient surgical center under  
 398.1 chapter 144; and (2) urgent care. For purposes of this subdivision, "urgent care" means

398.2 health services furnished to a person whose medical condition is sufficiently acute to  
398.3 require treatment unavailable through, or inappropriate to be provided by, a clinic or  
398.4 physician's office, but not so acute as to require treatment in a hospital emergency room.

398.5 (c) Sales, except for those listed in paragraph (d), to a critical access dental provider  
398.6 are exempt, if the items purchased are used in providing critical access dental care  
398.7 services. For the purposes of this subdivision, "critical access dental provider" means a  
398.8 dentist or dental clinic that qualifies under section 256B.76, subdivision 4, ~~paragraph (b)~~;  
398.9 and, in the previous calendar year, had no more than 15 percent of its patients covered by  
398.10 private dental insurance.

398.11 (d) This exemption does not apply to the following products and services:

398.12 (1) purchases made by a clinic, physician's office, or any other medical facility not  
398.13 operating as a hospital, outpatient surgical center, or critical access dental provider, even  
398.14 though the clinic, office, or facility may be owned and operated by a hospital, outpatient  
398.15 surgical center, or critical access dental provider;

398.16 (2) sales under section 297A.61, subdivision 3, paragraph (g), clause (2), and  
398.17 prepared food, candy, and soft drinks;

398.18 (3) building and construction materials used in constructing buildings or facilities  
398.19 that will not be used principally by the hospital, outpatient surgical center, or critical  
398.20 access dental provider;

398.21 (4) building, construction, or reconstruction materials purchased by a contractor or a  
398.22 subcontractor as a part of a lump-sum contract or similar type of contract with a guaranteed  
398.23 maximum price covering both labor and materials for use in the construction, alteration, or  
398.24 repair of a hospital, outpatient surgical center, or critical access dental provider; or

398.25 (5) the leasing of a motor vehicle as defined in section 297B.01, subdivision 11.

398.26 (e) A limited liability company also qualifies for exemption under this subdivision if  
398.27 (1) it consists of a sole member that would qualify for the exemption, and (2) the items  
398.28 purchased qualify for the exemption.

398.29 (f) An entity that contains both a hospital and a nonprofit unit may claim this  
398.30 exemption on purchases made for both the hospital and nonprofit unit provided that:

398.31 (1) the nonprofit unit would have qualified for exemption under subdivision 4; and

398.32 (2) the items purchased would have qualified for the exemption.

398.33 Sec. 61. Laws 2008, chapter 363, article 18, section 3, subdivision 5, is amended to read:

398.34 Subd. 5. **Basic Health Care Grants**

398.35 (a) **MinnesotaCare Grants**

399.1	<b>Health Care Access</b>	-0-	(770,000)
399.2	<b>Incentive Program and Outreach Grants.</b>		
399.3	Of the appropriation for the Minnesota health		
399.4	care outreach program in Laws 2007, chapter		
399.5	147, article 19, section 3, subdivision 7,		
399.6	paragraph (b):		
399.7	(1) \$400,000 in fiscal year 2009 from the		
399.8	general fund and \$200,000 in fiscal year 2009		
399.9	from the health care access fund are for the		
399.10	incentive program under Minnesota Statutes,		
399.11	section 256.962, subdivision 5. For the		
399.12	biennium beginning July 1, 2009, base level		
399.13	funding for this activity shall be \$360,000		
399.14	from the general fund and \$160,000 from the		
399.15	health care access fund; and		
399.16	(2) \$100,000 in fiscal year 2009 from the		
399.17	general fund and \$50,000 in fiscal year 2009		
399.18	from the health care access fund are for the		
399.19	outreach grants under Minnesota Statutes,		
399.20	section 256.962, subdivision 2. For the		
399.21	biennium beginning July 1, 2009, base level		
399.22	funding for this activity shall be \$90,000		
399.23	from the general fund and \$40,000 from the		
399.24	health care access fund.		
399.25	<b>(b) MA Basic Health Care Grants - Families</b>		
399.26	<b>and Children</b>	-0-	(17,280,000)
399.27	<b>Third-Party Liability.</b> (a) During		
399.28	fiscal year 2009, the commissioner shall		
399.29	employ a contractor paid on a percentage		
399.30	basis to improve third-party collections.		
399.31	Improvement initiatives may include, but not		
399.32	be limited to, efforts to improve postpayment		
399.33	collection from nonresponsive claims and		
399.34	efforts to uncover third-party payers the		
399.35	commissioner has been unable to identify.		

400.1 (b) In fiscal year 2009, the first \$1,098,000  
400.2 of recoveries, after contract payments and  
400.3 federal repayments, is appropriated to  
400.4 the commissioner for technology-related  
400.5 expenses.

400.6 ~~**Administrative Costs.** (a) For contracts~~  
400.7 ~~effective on or after January 1, 2009,~~  
400.8 ~~the commissioner shall limit aggregate~~  
400.9 ~~administrative costs paid to managed care~~  
400.10 ~~plans under Minnesota Statutes, section~~  
400.11 ~~256B.69, and to county-based purchasing~~  
400.12 ~~plans under Minnesota Statutes, section~~  
400.13 ~~256B.692, to an overall average of 6.6 percent~~  
400.14 ~~of total contract payments under Minnesota~~  
400.15 ~~Statutes, sections 256B.69 and 256B.692,~~  
400.16 ~~for each calendar year. For purposes of~~  
400.17 ~~this paragraph, administrative costs do not~~  
400.18 ~~include premium taxes paid under Minnesota~~  
400.19 ~~Statutes, section 297I.05, subdivision 5, and~~  
400.20 ~~provider surcharges paid under Minnesota~~  
400.21 ~~Statutes, section 256.9657, subdivision 3.~~

400.22 ~~(b) Notwithstanding any law to the contrary,~~  
400.23 ~~the commissioner may reduce or eliminate~~  
400.24 ~~administrative requirements to meet the~~  
400.25 ~~administrative target under paragraph (a).~~

400.26 ~~(c) Notwithstanding any contrary provision~~  
400.27 ~~of this article, this rider shall not expire.~~

400.28 **Hospital Payment Delay.** Notwithstanding  
400.29 Laws 2005, First Special Session chapter 4,  
400.30 article 9, section 2, subdivision 6, payments  
400.31 from the Medicaid Management Information  
400.32 System that would otherwise have been made  
400.33 for inpatient hospital services for medical  
400.34 assistance enrollees are delayed as follows:  
400.35 (1) for fiscal year 2008, June payments must



401.1 be included in the first payments in fiscal  
 401.2 year 2009; and (2) for fiscal year 2009,  
 401.3 June payments must be included in the first  
 401.4 payment of fiscal year 2010. The provisions  
 401.5 of Minnesota Statutes, section 16A.124,  
 401.6 do not apply to these delayed payments.  
 401.7 Notwithstanding any contrary provision in  
 401.8 this article, this paragraph expires on June  
 401.9 30, 2010.

401.10 **(c) MA Basic Health Care Grants - Elderly and**  
 401.11 **Disabled**

(14,028,000)

(9,368,000)

401.12 **Minnesota Disability Health Options Rate**  
 401.13 **Setting Methodology.** The commissioner  
 401.14 shall develop and implement a methodology  
 401.15 for risk adjusting payments for community  
 401.16 alternatives for disabled individuals (CADI)  
 401.17 and traumatic brain injury (TBI) home  
 401.18 and community-based waiver services  
 401.19 delivered under the Minnesota disability  
 401.20 health options program (MnDHO) effective  
 401.21 January 1, 2009. The commissioner shall  
 401.22 take into account the weighting system used  
 401.23 to determine county waiver allocations in  
 401.24 developing the new payment methodology.  
 401.25 Growth in the number of enrollees receiving  
 401.26 CADI or TBI waiver payments through  
 401.27 MnDHO is limited to an increase of 200  
 401.28 enrollees in each calendar year from January  
 401.29 2009 through December 2011. If those limits  
 401.30 are reached, additional members may be  
 401.31 enrolled in MnDHO for basic care services  
 401.32 only as defined under Minnesota Statutes,  
 401.33 section 256B.69, subdivision 28, and the  
 401.34 commissioner may establish a waiting list for  
 401.35 future access of MnDHO members to those  
 401.36 waiver services.

402.1 **MA Basic Elderly and Disabled**

402.2 **Adjustments.** For the fiscal year ending June  
 402.3 30, 2009, the commissioner may adjust the  
 402.4 rates for each service affected by rate changes  
 402.5 under this section in such a manner across  
 402.6 the fiscal year to achieve the necessary cost  
 402.7 savings and minimize disruption to service  
 402.8 providers, notwithstanding the requirements  
 402.9 of Laws 2007, chapter 147, article 7, section  
 402.10 71.

402.11 **(d) General Assistance Medical Care Grants** -0- (6,971,000)

402.12 **(e) Other Health Care Grants** -0- (17,000)

402.13 **MinnesotaCare Outreach Grants Special**

402.14 **Revenue Account.** The balance in the  
 402.15 MinnesotaCare outreach grants special  
 402.16 revenue account on July 1, 2009, estimated  
 402.17 to be \$900,000, must be transferred to the  
 402.18 general fund.

402.19 **Grants Reduction.** Effective July 1, 2008,  
 402.20 base level funding for nonforecast, general  
 402.21 fund health care grants issued under this  
 402.22 paragraph shall be reduced by 1.8 percent at  
 402.23 the allotment level.

402.24 Sec. 62. Laws 2014, chapter 312, article 24, section 45, subdivision 2, is amended to  
 402.25 read:

402.26 Subd. 2. **Application for and terms of variance.** A new provider may apply to the  
 402.27 commissioner, on a form supplied by the commissioner for this purpose, for a variance  
 402.28 from special transportation service operating standards. The commissioner may grant or  
 402.29 deny the variance application. Variances expire on the earlier of February 1, ~~2016~~ 2017, or  
 402.30 ~~the date that the commissioner of transportation begins certifying new providers under the~~  
 402.31 ~~terms of this act and successor legislation~~ one year after the date the variance was issued.

402.32 The commissioner must not grant variances under this subdivision after June 30, 2016.

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

403.1       Sec. 63. **ADVISORY GROUP ON ADMINISTRATIVE EFFICIENCY AND**  
403.2 **REGULATORY SIMPLIFICATION.**

403.3           (a) The commissioner of human services, in consultation with the commissioner  
403.4 of health shall convene an advisory group on maximizing administrative efficiency  
403.5 and regulatory simplification in state public health care programs. The advisory group  
403.6 shall develop recommendations for consistent regulatory and licensure requirements,  
403.7 guidelines, definitions, and reporting standards, including a common standardized public  
403.8 reporting template for health maintenance organizations and county-based purchasing  
403.9 plans that participate in state public health care programs. The advisory group shall take  
403.10 into consideration relevant reporting standards of the National Association of Insurance  
403.11 Commissioners and the Centers for Medicare and Medicaid Services.

403.12           (b) The membership of the advisory group shall be comprised of the following:

403.13           (1) the commissioner of health or designee;

403.14           (2) the commissioner of human services or designee;

403.15           (3) the commissioner of commerce or designee;

403.16           (4) representatives of the health maintenance organizations and county-based  
403.17 purchasing plans; and

403.18           (5) representatives of public and private health care experts and consumer  
403.19 representatives, including at least one from a nonprofit organization with legal expertise  
403.20 representing low-income consumers.

403.21           (c) The commissioner of health shall submit a report of the recommendations of the  
403.22 advisory group to the chairs and ranking minority members of the legislative committees  
403.23 with jurisdiction over state public health care programs by February 1, 2017.

403.24           (d) The advisory group shall expire the day after submitting the report required  
403.25 under paragraph (c).

403.26       Sec. 64. **STATEWIDE OPIOID PRESCRIBING IMPROVEMENT PROGRAM.**

403.27           The commissioner of human services, in collaboration with the commissioner of  
403.28 health, shall report to the legislature by December 1, 2015, on recommendations made  
403.29 by the opioid prescribing work group under Minnesota Statutes, section 256B.0638,  
403.30 subdivision 4, and steps taken by the commissioner of human services to implement the  
403.31 opioid prescribing improvement program under Minnesota Statutes, section 256B.0638,  
403.32 subdivision 5.

403.33       Sec. 65. **TASK FORCE ON HEALTH CARE FINANCING.**

404.1 Subdivision 1. **Task force.** (a) The governor shall convene a task force on health  
404.2 care financing to advise the governor and legislature on strategies that will increase access  
404.3 to and improve the quality of health care for Minnesotans. These strategies shall include  
404.4 options for sustainable health care financing, coverage, purchasing, and delivery for all  
404.5 insurance affordability programs, including MNsure, medical assistance, MinnesotaCare,  
404.6 and individuals eligible to purchase coverage with federal advanced premium tax credits  
404.7 and cost-sharing subsidies.

404.8 (b) The task force shall consist of:

404.9 (1) seven members appointed by the senate, four members appointed by the majority  
404.10 leader of the senate, one of whom must be a legislator; and three members appointed by  
404.11 the minority leader of the senate, one of whom must be a legislator;

404.12 (2) seven members of the house of representatives, four members appointed by the  
404.13 speaker of the house, one of whom must be a legislator; and three members appointed by  
404.14 the minority leader of the house of representatives, one of whom must be a legislator;

404.15 (3) 11 members appointed by the governor, including public and private health care  
404.16 experts and consumer representatives. The consumer representatives must include one  
404.17 member from a nonprofit organization with legal expertise representing low-income  
404.18 consumers, at least one member from a broad-based nonprofit consumer advocacy  
404.19 organization, and at least one member from an organization representing consumers of  
404.20 color; and

404.21 (4) the commissioners of MNsure, commerce, and health, or their designees.

404.22 (c) The commissioner of human services and a member of the task force voted  
404.23 by the task force shall serve as cochairs of the task force. The commissioner of human  
404.24 services shall convene the first meeting and the members shall vote on the cochair position  
404.25 at the first meeting.

404.26 Subd. 2. **Duties.** (a) The task force shall consider opportunities, including  
404.27 alternatives to MNsure, options under section 1332 of the Patient Protection and Affordable  
404.28 Care Act, and options under a section 1115 waiver of the Social Security Act, including:

404.29 (1) options for providing and financing seamless coverage for persons  
404.30 otherwise eligible for insurance affordability programs, including medical assistance,  
404.31 MinnesotaCare, and advanced premium tax credits used to purchase commercial  
404.32 insurance. This includes, but is not limited to: alignment of eligibility and enrollment  
404.33 requirements; smoothing consumer cost-sharing across programs; alignment and  
404.34 alternatives to benefit sets; alternatives to the individual mandate; the employer mandate  
404.35 and penalties; advanced premium tax credits; and qualified health plans;

405.1 (2) options for transforming health care purchasing and delivery, including, but not  
 405.2 limited to: expansion of value-based direct contracting with providers and other entities  
 405.3 to reward improved health outcomes and reduced costs, including selective contracting;  
 405.4 contracting to provide services to public programs and commercial products; and payment  
 405.5 models that support and reward coordination of care across the continuum of services  
 405.6 and programs;

405.7 (3) options for alignment, consolidation, and governance of certain operational  
 405.8 components, including, but not limited to: MNsure; program eligibility, enrollment, call  
 405.9 centers, and contracting; and the shared eligibility IT platform; and

405.10 (4) examining the impact of options on the health care workforce and delivery  
 405.11 system, including, but not limited to, rural and safety net providers, clinics, and hospitals.

405.12 (b) In development of the options in paragraph (a), the task force options and  
 405.13 recommendations shall include the following goals:

405.14 (1) seamless consumer experience across all programs;

405.15 (2) reducing barriers to accessibility and affordability of coverage;

405.16 (3) improving sustainable financing of health programs, including impact on the  
 405.17 state budget;

405.18 (4) assessing the impact of options for innovation on their potential to reduce  
 405.19 health disparities;

405.20 (5) expanding innovative health care purchasing and delivery systems strategies that  
 405.21 reduce cost and improve health;

405.22 (6) promoting effectively and efficiently aligning program resources and operations;

405.23 and

405.24 (7) increasing transparency and accountability of program operations.

405.25 Subd. 3. **Staff.** (a) The commissioner of human services shall provide staff and  
 405.26 administrative services for the task force. The commissioner may accept outside resources  
 405.27 to help support its efforts and shall leverage its existing vendor contracts to provide  
 405.28 technical expertise to develop options under subdivision 2. The commissioner of human  
 405.29 services shall receive expedited review and publication of competitive procurements for  
 405.30 additional vendor support needed to support the task force.

405.31 (b) Technical assistance shall be provided by the Departments of Health, Commerce,  
 405.32 Human Services, and Management and Budget.

405.33 Subd. 4. **Report.** The commissioner of human services shall submit  
 405.34 recommendations by January 15, 2016, to the governor and the chairs and ranking  
 405.35 minority members of the legislative committees with jurisdiction over health, human  
 405.36 services, and commerce policy and finance.

406.1 Subd. 5. **Expiration.** The task force expires the day after submitting the report  
406.2 required under subdivision 4.

406.3 **Sec. 66. HEALTH DISPARITIES PAYMENT ENHANCEMENT.**

406.4 (a) The commissioner of human services shall develop a methodology to pay a  
406.5 higher payment rate for health care providers and services that takes into consideration  
406.6 the higher cost, complexity, and resources needed to serve patients and populations  
406.7 who experience the greatest health disparities in order to achieve the same health and  
406.8 quality outcomes that are achieved for other patients and populations. In developing  
406.9 the methodology, the commissioner shall take into consideration all existing payment  
406.10 methods and rates, including add-on or enhanced rates paid to providers serving high  
406.11 concentrations of low-income patients or populations or providing access in underserved  
406.12 regions or populations. The new methodology must not result in a net decrease in total  
406.13 payment from all sources for those providers who qualify for additional add-on payments  
406.14 or enhanced payments, including, but not limited to, critical access dental, community  
406.15 clinic add-ons, federally qualified health centers payment rates, and disproportionate share  
406.16 payments. The commissioner shall develop the methodology in consultation with affected  
406.17 stakeholders, including communities impacted by health disparities, using culturally  
406.18 appropriate methods of community engagement. The proposed methodology must include  
406.19 recommendations for how the methodology could be incorporated into payment methods  
406.20 used in both fee-for-service and managed care plans.

406.21 (b) The commissioner shall submit a report on the analysis and provide options  
406.22 for new payment methodologies that incorporate health disparities to the chairs and  
406.23 ranking minority members of the legislative committees with jurisdiction over health care  
406.24 policy and finance by February 1, 2016. The scope of the report and the development  
406.25 work described in paragraph (a) is limited to data currently available to the Department  
406.26 of Human Services; analyses of the data for reliability and completeness; analyses of  
406.27 how these data relate to health disparities, outcomes, and expenditures; and options for  
406.28 incorporating these data or measures into a payment methodology.

406.29 **Sec. 67. REPEALER.**

406.30 (a) Minnesota Statutes 2014, sections 256.969, subdivisions 23 and 30; and 256B.69,  
406.31 subdivision 32, are repealed and effective July 1, 2015.

406.32 (b) Minnesota Statutes 2014, sections 256L.02, subdivision 3; and 256L.05,  
406.33 subdivisions 1b, 1c, 3c, and 5, are repealed and effective the day following final enactment.

407.1 (c) Minnesota Statutes 2014, section 256L.11, subdivision 7, is repealed and  
407.2 effective July 1, 2015.

407.3 (d) Minnesota Rules, part 8840.5900, subparts 12 and 14, are repealed and effective  
407.4 January 1, 2016.

## 407.5 **ARTICLE 11**

### 407.6 **MNSURE**

407.7 Section 1. Minnesota Statutes 2014, section 15.01, is amended to read:

#### 407.8 **15.01 DEPARTMENTS OF THE STATE.**

407.9 The following agencies are designated as the departments of the state government:  
407.10 the Department of Administration; the Department of Agriculture; the Department of  
407.11 Commerce; the Department of Corrections; the Department of Education; the Department  
407.12 of Employment and Economic Development; the Department of Health; the Department  
407.13 of Human Rights; the Department of Labor and Industry; the Department of Management  
407.14 and Budget; the Department of Military Affairs; the Department of Natural Resources;  
407.15 the Department of Public Safety; the Department of Human Services; the Department of  
407.16 Revenue; the Department of Transportation; the Department of Veterans Affairs; the  
407.17 Department of MNsure; and their successor departments.

407.18 Sec. 2. Minnesota Statutes 2014, section 15A.0815, subdivision 2, is amended to read:

407.19 Subd. 2. **Group I salary limits.** The salary for a position listed in this subdivision  
407.20 shall not exceed 133 percent of the salary of the governor. This limit must be adjusted  
407.21 annually on January 1. The new limit must equal the limit for the prior year increased  
407.22 by the percentage increase, if any, in the Consumer Price Index for all urban consumers  
407.23 from October of the second prior year to October of the immediately prior year. The  
407.24 commissioner of management and budget must publish the limit on the department's Web  
407.25 site. This subdivision applies to the following positions:

407.26 Commissioner of administration;

407.27 Commissioner of agriculture;

407.28 Commissioner of education;

407.29 Commissioner of commerce;

407.30 Commissioner of corrections;

407.31 Commissioner of health;

407.32 Commissioner, Minnesota Office of Higher Education;

407.33 Commissioner, Housing Finance Agency;

408.1 Commissioner of human rights;  
 408.2 Commissioner of human services;  
 408.3 Commissioner of labor and industry;  
 408.4 Commissioner of management and budget;  
 408.5 Commissioner of MNsure;  
 408.6 Commissioner of natural resources;  
 408.7 Commissioner, Pollution Control Agency;  
 408.8 Executive director, Public Employees Retirement Association;  
 408.9 Commissioner of public safety;  
 408.10 Commissioner of revenue;  
 408.11 Executive director, State Retirement System;  
 408.12 Executive director, Teachers Retirement Association;  
 408.13 Commissioner of employment and economic development;  
 408.14 Commissioner of transportation; and  
 408.15 Commissioner of veterans affairs.

408.16 Sec. 3. Minnesota Statutes 2014, section 62A.02, subdivision 2, is amended to read:

408.17 Subd. 2. **Approval.** (a) The health plan form shall not be issued, nor shall any  
 408.18 application, rider, endorsement, or rate be used in connection with it, until the expiration  
 408.19 of 60 days after it has been filed unless the commissioner approves it before that time.

408.20 (b) Notwithstanding paragraph (a), a rate filed with respect to a policy of accident and  
 408.21 sickness insurance as defined in section 62A.01 by an insurer licensed under chapter 60A,  
 408.22 may be used on or after the date of filing with the commissioner. Rates that are not approved  
 408.23 or disapproved within the 60-day time period are deemed approved. This paragraph does  
 408.24 not apply to Medicare-related coverage as defined in section 62A.3099, subdivision 17.

408.25 (c) For coverage to begin on or after January 1, 2016, and each January 1 thereafter,  
 408.26 health plans in the individual and small group markets that are not grandfathered plans to  
 408.27 be offered outside MNsure and qualified health plans to be offered inside MNsure must  
 408.28 receive rate approval from the commissioner no later than 30 days prior to the beginning  
 408.29 of the annual open enrollment period for MNsure. Premium rates for all carriers in the  
 408.30 applicable market for the next calendar year must be made available to the public by the  
 408.31 commissioner only after all rates for the applicable market are final and approved. Final  
 408.32 and approved rates must be publicly released at a uniform time for all individual and small  
 408.33 group health plans that are not grandfathered plans to be offered outside MNsure and  
 408.34 qualified health plans to be offered inside MNsure, and no later than 30 days prior to the  
 408.35 beginning of the annual open enrollment period for MNsure.



409.1 Sec. 4. Minnesota Statutes 2014, section 62V.02, subdivision 2, is amended to read:

409.2 Subd. 2. **Board Commissioner.** "~~Board~~" "Commissioner" means the ~~Board of~~  
409.3 ~~Directors~~ commissioner of MNsure ~~specified in section 62V.04.~~

409.4 Sec. 5. Minnesota Statutes 2014, section 62V.02, is amended by adding a subdivision  
409.5 to read:

409.6 Subd. 2a. **Consumer assistance partner.** "Consumer assistance partner" means  
409.7 individuals and entities certified by the commissioner to serve as navigators, in-person  
409.8 assisters, or certified application counselors.

409.9 Sec. 6. Minnesota Statutes 2014, section 62V.02, subdivision 11, is amended to read:

409.10 Subd. 11. **Qualified health plan.** "Qualified health plan" means a health plan that  
409.11 meets the definition in section 1301(a) of the Affordable Care Act, Public Law 111-148,  
409.12 and has been certified by the ~~board~~ commissioner in accordance with section 62V.05,  
409.13 subdivision 5, to be offered through MNsure.

409.14 Sec. 7. Minnesota Statutes 2014, section 62V.03, is amended to read:

409.15 **62V.03 MNSURE; ESTABLISHMENT.**

409.16 Subdivision 1. **Creation.** MNsure is created as a ~~board under section 15.012,~~  
409.17 ~~paragraph (a),~~ department of the state government under section 15.01 to:

409.18 (1) promote informed consumer choice, innovation, competition, quality, value,  
409.19 market participation, affordability, suitable and meaningful choices, health improvement,  
409.20 care management, reduction of health disparities, and portability of health plans;

409.21 (2) facilitate and simplify the comparison, choice, enrollment, and purchase of  
409.22 health plans for individuals purchasing in the individual market through MNsure and for  
409.23 employees and employers purchasing in the small group market through MNsure;

409.24 (3) assist small employers with access to small business health insurance tax credits  
409.25 and to assist individuals with access to public health care programs, premium assistance  
409.26 tax credits and cost-sharing reductions, and certificates of exemption from individual  
409.27 responsibility requirements;

409.28 (4) facilitate the integration and transition of individuals between public health care  
409.29 programs and health plans in the individual or group market and develop processes that, to  
409.30 the maximum extent possible, provide for continuous coverage; and

409.31 (5) establish and modify as necessary a name and brand for MNsure based on market  
409.32 studies that show maximum effectiveness in attracting the uninsured and motivating  
409.33 them to take action.

410.1 Subd. 2. **Application of other law.** (a) ~~MNsure must be reviewed~~ is subject to  
410.2 audit by the legislative auditor under ~~section 3.971~~. ~~The legislative auditor shall audit~~  
410.3 ~~the books, accounts, and affairs of MNsure once each year or less frequently as the~~  
410.4 ~~legislative auditor's funds and personnel permit. Upon the audit of the financial accounts~~  
410.5 ~~and affairs of MNsure, MNsure is liable to the state for the total cost and expenses of the~~  
410.6 ~~audit, including the salaries paid to the examiners while actually engaged in making the~~  
410.7 ~~examination. The legislative auditor may bill MNsure either monthly or at the completion~~  
410.8 ~~of the audit. All collections received for the audits must be deposited in the general fund~~  
410.9 ~~and are appropriated to the legislative auditor. Pursuant to section 3.97, subdivision 3a,~~  
410.10 ~~the Legislative Audit Commission is requested to direct the legislative auditor to report by~~  
410.11 ~~March 1, 2014, to the legislature on any duplication of services that occurs within state~~  
410.12 ~~government as a result of the creation of MNsure. The legislative auditor may make~~  
410.13 ~~recommendations on consolidating or eliminating any services deemed duplicative. The~~  
410.14 ~~board shall reimburse the legislative auditor for any costs incurred in the creation of~~  
410.15 ~~this report.~~

410.16 (b) ~~Board members of MNsure are subject to sections 10A.07 and 10A.09. Board~~  
410.17 ~~members and the personnel of MNsure are subject to section 10A.071.~~

410.18 (c) ~~All meetings of the board shall comply with the open meeting law in chapter~~  
410.19 ~~13D, except that:~~

410.20 (1) ~~meetings, or portions of meetings, regarding compensation negotiations with the~~  
410.21 ~~director or managerial staff may be closed in the same manner and according to the same~~  
410.22 ~~procedures identified in section 13D.03;~~

410.23 (2) ~~meetings regarding contract negotiation strategy may be closed in the same~~  
410.24 ~~manner and according to the same procedures identified in section 13D.05, subdivision 3,~~  
410.25 ~~paragraph (c); and~~

410.26 (3) ~~meetings, or portions of meetings, regarding not public data described in section~~  
410.27 ~~62V.06, subdivision 3, and regarding trade secret information as defined in section 13.37,~~  
410.28 ~~subdivision 1, paragraph (b), are closed to the public, but must otherwise comply with~~  
410.29 ~~the procedures identified in chapter 13D.~~

410.30 (d) ~~(b)~~ MNsure and provisions specified under this chapter are exempt from:

410.31 (1) ~~chapter 14, including section 14.386, except as specified in section 62V.05; and~~

410.32 (2) ~~chapters 16B and 16C, with the exception of sections 16C.08, subdivision~~  
410.33 ~~2, paragraph (b), clauses (1) to (8); 16C.086; 16C.09, paragraph (a), clauses (1) and~~  
410.34 ~~(3), paragraph (b), and paragraph (c); and section 16C.16. However, MNsure the~~  
410.35 ~~commissioner, in consultation with the commissioner of administration, shall implement~~  
410.36 ~~policies and procedures to establish an open and competitive procurement process~~

411.1 for MNsure that, to the extent practicable, conforms to the principles and procedures  
 411.2 contained in chapters 16B and 16C. In addition, MNsure the commissioner may enter into  
 411.3 an agreement with the commissioner of administration for other services.

411.4 ~~(e) The board and (c) The Web site~~ are ~~is~~ exempt from chapter 60K. Any employee  
 411.5 of MNsure who sells, solicits, or negotiates insurance to individuals or small employers  
 411.6 must be licensed as an insurance producer under chapter 60K.

411.7 ~~(f) (d)~~ Section 3.3005 applies to any federal funds received by MNsure.

411.8 ~~(g) MNsure is exempt from the following sections in chapter 16E: 16E.01,~~  
 411.9 ~~subdivision 3, paragraph (b); 16E.03, subdivisions 3 and 4; 16E.04, subdivision 1,~~  
 411.10 ~~subdivision 2, paragraph (c), and subdivision 3, paragraph (b); 16E.0465; 16E.055;~~  
 411.11 ~~16E.145; 16E.15; 16E.16; 16E.17; 16E.18; and 16E.22.~~

411.12 ~~(h) A MNsure decision that requires a vote of the board, other than a decision that~~  
 411.13 ~~applies only to hiring of employees or other internal management of MNsure, is an~~  
 411.14 ~~"administrative action" under section 10A.01, subdivision 2.~~

411.15 Subd. 3. **Continued operation of a private marketplace.** (a) Nothing in this  
 411.16 chapter shall be construed to prohibit: (1) a health carrier from offering outside of MNsure  
 411.17 a health plan to a qualified individual or qualified employer; and (2) a qualified individual  
 411.18 from enrolling in, or a qualified employer from selecting for its employees, a health plan  
 411.19 offered outside of MNsure.

411.20 (b) Nothing in this chapter shall be construed to restrict the choice of a qualified  
 411.21 individual to enroll or not enroll in a qualified health plan or to participate in MNsure.  
 411.22 Nothing in this chapter shall be construed to compel an individual to enroll in a qualified  
 411.23 health plan or to participate in MNsure.

411.24 (c) For purposes of this subdivision, "qualified individual" and "qualified employer"  
 411.25 have the meanings given in section 1312 of the Affordable Care Act, Public Law 111-148,  
 411.26 and further defined through amendments to the act and regulations issued under the act.

411.27 Sec. 8. **[62V.041] GOVERNANCE OF THE SHARED ELIGIBILITY SYSTEM.**

411.28 Subdivision 1. **Definition; shared eligibility system.** "Shared eligibility system"  
 411.29 means the system that supports eligibility determinations using a modified adjusted gross  
 411.30 income methodology for medical assistance under section 256B.056, subdivision 1a,  
 411.31 paragraph (b), clause (1); MinnesotaCare under chapter 256L; and qualified health plan  
 411.32 enrollment under section 62V.05, subdivision 5, paragraph (c).

411.33 Subd. 2. **Executive steering committee.** The shared eligibility system shall be  
 411.34 governed and administered by a seven-member executive steering committee. The  
 411.35 steering committee shall consist of two members appointed by the commissioner of

412.1 human services, two members appointed by the commissioner of MNsure, two members  
 412.2 appointed by the commissioner of MN.IT, and one county representative appointed by the  
 412.3 commissioner of human services. The commissioner of human services shall designate  
 412.4 one of the members appointed by the commissioner of human services to serve as the  
 412.5 chair of the steering committee.

412.6 Subd. 3. **Duties.** (a) The steering committee shall establish an overall governance  
 412.7 structure of the shared eligibility system, and shall be responsible for the overall  
 412.8 governance of the system, including setting goals and priorities, allocating the system's  
 412.9 resources, and making major system decisions.

412.10 (b) The steering committee shall adopt bylaws, policies, and interagency agreements  
 412.11 necessary to administer the shared eligibility system.

412.12 Subd. 4. **Decision making.** The steering committee, to the extent feasible, shall  
 412.13 operate under a consensus model. The steering committee shall make decisions that give  
 412.14 particular attention to parts of the system with the largest enrollments and the greatest risks.

412.15 Subd. 5. **Administrative structure.** MN.IT services shall be responsible for the  
 412.16 design, build, maintenance, operation, and upgrade of the information technology for the  
 412.17 shared eligibility system. MN.IT services shall carry out its responsibilities under the  
 412.18 governance of the executive steering committee and this section.

412.19 Sec. 9. **[62V.042] ADVISORY COMMITTEES.**

412.20 Subdivision 1. **Advisory committees.** (a) The commissioner shall establish and  
 412.21 maintain advisory committees to provide insurance producers, health care providers, the  
 412.22 health care industry, consumers, and other stakeholders with the opportunity to advise the  
 412.23 commissioner regarding the operation of MNsure as required under section 1311(d)(6) of  
 412.24 the Affordable Care Act, Public Law 111-148. The commissioner shall regularly consult  
 412.25 with the advisory committees, and, at a minimum, convene each advisory committee at  
 412.26 least quarterly. The advisory committees established under this paragraph shall not expire.

412.27 (b) The commissioner, in consultation with the commissioner of human services,  
 412.28 shall establish an advisory committee to advise the commissioner on the MNsure  
 412.29 enrollment process. The committee must include:

412.30 (1) health care consumers who are enrollees in qualified health plans;

412.31 (2) individuals and entities with experience in facilitating enrollment in qualified  
 412.32 health plans;

412.33 (3) representatives of small employers and self-employed individuals;

412.34 (4) advocates for enrolling hard-to-reach populations; and

413.1 (5) other members, as determined by the commissioner or the commissioner of  
 413.2 human services.

413.3 The advisory committee established under this paragraph shall not expire, except by  
 413.4 action of the commissioner.

413.5 (c) The commissioner may establish additional advisory committees, as necessary,  
 413.6 to gather and provide information to the commissioner in order to facilitate the operation  
 413.7 of MNsure. The advisory committees established under this paragraph shall not expire,  
 413.8 except by action by the commissioner.

413.9 (d) Section 15.0597 shall not apply to any advisory committee established by the  
 413.10 commissioner under this subdivision.

413.11 (e) The commissioner may provide compensation and expense reimbursement under  
 413.12 section 15.059, subdivision 3, to members of the advisory committees.

413.13 (f) The advisory committees established under this subdivision are subject to the  
 413.14 Open Meeting Law in chapter 13D.

413.15 Sec. 10. Minnesota Statutes 2014, section 62V.05, is amended to read:

413.16 **62V.05 RESPONSIBILITIES AND POWERS OF MNSURE.**

413.17 Subdivision 1. **General.** (a) The ~~board~~ commissioner shall operate MNsure  
 413.18 according to this chapter and applicable state and federal law.

413.19 (b) The ~~board~~ commissioner has the power to:

413.20 (1) ~~employ personnel and delegate administrative, operational, and other~~  
 413.21 ~~responsibilities to the director and other personnel as deemed appropriate by the board.~~  
 413.22 ~~This authority is subject to chapters 43A and 179A. The director and managerial staff of~~  
 413.23 ~~MNsure shall serve in the unclassified service and shall be governed by a compensation~~  
 413.24 ~~plan prepared by the board, submitted to the commissioner of management and budget~~  
 413.25 ~~for review and comment within 14 days of its receipt, and approved by the Legislative~~  
 413.26 ~~Coordinating Commission and the legislature under section 3.855, except that section~~  
 413.27 ~~15A.0815, subdivision 5, paragraph (c), shall not apply;~~

413.28 (2) ~~establish the budget of MNsure;~~

413.29 (3) ~~seek and accept money, grants, loans, donations, materials, services, or~~  
 413.30 ~~advertising revenue from government agencies, philanthropic organizations, and public~~  
 413.31 ~~and private sources to fund the operation of MNsure. No health carrier or insurance~~  
 413.32 ~~producer shall advertise on MNsure;~~

413.33 (4) ~~(2)~~ (2) contract for the receipt and provision of goods and services;

413.34 (5) ~~(3)~~ (3) enter into information-sharing agreements with federal and state agencies  
 413.35 and other entities, provided the agreements include adequate protections with respect to

414.1 the confidentiality and integrity of the information to be shared, and comply with all  
414.2 applicable state and federal laws, regulations, and rules, including the requirements of  
414.3 section 62V.06; and

414.4 ~~(6)~~ (4) exercise all powers reasonably necessary to implement and administer the  
414.5 requirements of this chapter and the Affordable Care Act, Public Law 111-148.

414.6 (c) The ~~board~~ commissioner shall establish policies and procedures to gather public  
414.7 comment and provide public notice in the State Register.

414.8 ~~(d) Within 180 days of enactment, the board shall establish bylaws, policies, and~~  
414.9 ~~procedures governing the operations of MNsure in accordance with this chapter.~~

414.10 Subd. 2. **Operations funding.** (a) Prior to January 1, 2015, MNsure shall retain or  
414.11 collect up to 1.5 percent of total premiums for individual and small group market health  
414.12 plans and dental plans sold through MNsure to fund the cash reserves of MNsure, but  
414.13 the amount collected shall not exceed a dollar amount equal to 25 percent of the funds  
414.14 collected under section 62E.11, subdivision 6, for calendar year 2012.

414.15 (b) Beginning January 1, 2015, MNsure shall retain or collect up to 3.5 percent of  
414.16 total premiums for individual and small group market health plans and dental plans sold  
414.17 through MNsure to fund the operations of MNsure, but the amount collected shall not  
414.18 exceed a dollar amount equal to 50 percent of the funds collected under section 62E.11,  
414.19 subdivision 6, for calendar year 2012.

414.20 (c) Beginning January 1, 2016, MNsure shall retain or collect up to 3.5 percent of  
414.21 total premiums for individual and small group market health plans and dental plans sold  
414.22 through MNsure to fund the operations of MNsure, but the amount collected may never  
414.23 exceed a dollar amount greater than 100 percent of the funds collected under section  
414.24 62E.11, subdivision 6, for calendar year 2012.

414.25 (d) For fiscal years 2014 and 2015, the commissioner of management and budget is  
414.26 authorized to provide cash flow assistance of up to \$20,000,000 from the special revenue  
414.27 fund or the statutory general fund under section 16A.671, subdivision 3, paragraph (a),  
414.28 to MNsure. Any funds provided under this paragraph shall be repaid, with interest, by  
414.29 June 30, 2015.

414.30 (e) Funding for the operations of MNsure shall cover any compensation provided to  
414.31 navigators participating in the navigator program.

414.32 Subd. 3. **Insurance producers.** (a) ~~By April 30, 2013, The board~~ commissioner, in  
414.33 consultation with the commissioner of commerce, shall establish certification requirements  
414.34 that must be met by insurance producers in order to assist individuals and small employers  
414.35 with purchasing coverage through MNsure. ~~Prior to January 1, 2015, the board may~~  
414.36 ~~amend the requirements, only if necessary, due to a change in federal rules.~~

415.1 (b) Certification requirements shall not exceed the requirements established  
415.2 under Code of Federal Regulations, title 45, part 155.220. Certification shall include  
415.3 training on health plans available through MNsure, available tax credits and cost-sharing  
415.4 arrangements, compliance with privacy and security standards, eligibility verification  
415.5 processes, online enrollment tools, and basic information on available public health care  
415.6 programs. Training required for certification under this subdivision shall qualify for  
415.7 continuing education requirements for insurance producers required under chapter 60K,  
415.8 and must comply with course approval requirements under chapter 45.

415.9 (c) Producer compensation shall be established by health carriers that provide health  
415.10 plans through MNsure. The structure of compensation to insurance producers must be  
415.11 similar for health plans sold through MNsure and outside MNsure.

415.12 (d) Any insurance producer compensation structure established by a health carrier  
415.13 for the small group market must include compensation for defined contribution plans that  
415.14 involve multiple health carriers. The compensation offered must be commensurate with  
415.15 other small group market defined health plans.

415.16 (e) Any insurance producer assisting an individual or small employer with purchasing  
415.17 coverage through MNsure must disclose, orally and in writing, to the individual or small  
415.18 employer at the time of the first solicitation with the prospective purchaser the following:

415.19 (1) the health carriers and qualified health plans offered through MNsure that the  
415.20 producer is authorized to sell, and that the producer may not be authorized to sell all the  
415.21 qualified health plans offered through MNsure;

415.22 (2) that the producer may be receiving compensation from a health carrier for  
415.23 enrolling the individual or small employer into a particular health plan; and

415.24 (3) that information on all qualified health plans offered through MNsure is available  
415.25 through the MNsure Web site.

415.26 For purposes of this paragraph, "solicitation" means any contact by a producer, or any  
415.27 person acting on behalf of a producer made for the purpose of selling or attempting to sell  
415.28 coverage through MNsure. If the first solicitation is made by telephone, the disclosures  
415.29 required under this paragraph need not be made in writing, but the fact that disclosure  
415.30 has been made must be acknowledged on the application.

415.31 (f) Beginning January 15, 2015, each health carrier that offers or sells qualified  
415.32 health plans through MNsure shall report in writing to the ~~board~~ commissioner and the  
415.33 commissioner of commerce the compensation and other incentives it offers or provides  
415.34 to insurance producers with regard to each type of health plan the health carrier offers  
415.35 or sells both inside and outside of MNsure. Each health carrier shall submit a report

416.1 annually and upon any change to the compensation or other incentives offered or provided  
416.2 to insurance producers.

416.3 (g) Nothing in this chapter shall prohibit an insurance producer from offering  
416.4 professional advice and recommendations to a small group purchaser based upon  
416.5 information provided to the producer.

416.6 (h) An insurance producer that offers health plans in the small group market shall  
416.7 notify each small group purchaser of which group health plans qualify for Internal  
416.8 Revenue Service approved section 125 tax benefits. The insurance producer shall also  
416.9 notify small group purchasers of state law provisions that benefit small group plans when  
416.10 the employer agrees to pay 50 percent or more of its employees' premium. Individuals  
416.11 who are eligible for cost-effective medical assistance will count toward the 75 percent  
416.12 participation requirement in section 62L.03, subdivision 3.

416.13 (i) Nothing in this subdivision shall be construed to limit the licensure requirements  
416.14 or regulatory functions of the commissioner of commerce under chapter 60K.

416.15 (j) The commissioners of human services and MNsure, upon federal approval, shall  
416.16 establish an insurance producer incentive program to compensate insurance producers  
416.17 for providing application enrollment assistance for public health care programs. The  
416.18 program must include certification training standards for insurance producers seeking  
416.19 compensation under the incentive program. The standards must meet the training modules  
416.20 specified under Minnesota Rules, part 7700.0050, subpart 1, and the training program must  
416.21 not exceed eight hours to complete. This training program shall qualify for eight hours  
416.22 of continuing education credits on public health care programs for insurance producers  
416.23 required under chapter 60K and must comply with course approval requirements under  
416.24 chapter 45. The amount of compensation to be paid to an insurance producer under this  
416.25 program is established in section 256.962, subdivision 5.

416.26 Subd. 4. **Navigator; in-person assisters; call center.** (a) ~~The board~~ commissioner  
416.27 shall establish policies and procedures for the ongoing operation of a navigator program,  
416.28 in-person assister program, call center, and customer service provisions for MNsure to be  
416.29 implemented beginning January 1, 2015.

416.30 (b) ~~Until the implementation of the policies and procedures described in paragraph~~  
416.31 ~~(a), the following shall be in effect:~~

416.32 (1) ~~the navigator program shall be met by section 256.962;~~

416.33 (2) ~~entities eligible to be navigators, including entities defined in Code of Federal~~  
416.34 ~~Regulations, title 45, part 155.210 (c)(2), may serve as in-person assisters;~~

416.35 (3) ~~The board~~ commissioner shall establish requirements and compensation for  
416.36 the navigator program and the in-person assister program by April 30, 2013. Entities



417.1 eligible to be navigators, including entities defined in Code of Federal Regulations, title  
 417.2 45, part 155.210(c)(2), may serve as in-person assisters. Compensation for navigators  
 417.3 and in-person assisters must take into account any other compensation received by the  
 417.4 navigator or in-person assister for conducting the same or similar services; and.

417.5 ~~(4)~~ (c) Call center operations shall utilize existing state resources and personnel,  
 417.6 including referrals to counties for medical assistance.

417.7 ~~(e)~~ (d) The board commissioner shall establish a toll-free number for MNsure and  
 417.8 may hire and contract for additional resources as deemed necessary.

417.9 ~~(d)~~ (e) The navigator program and in-person assister program must meet the  
 417.10 requirements of section 1311(i) of the Affordable Care Act, Public Law 111-148. In  
 417.11 establishing training standards for the navigators and in-person assisters, the board  
 417.12 commissioner must ensure that all entities and individuals carrying out navigator and  
 417.13 in-person assister functions have training in the needs of underserved and vulnerable  
 417.14 populations; eligibility and enrollment rules and procedures; the range of available public  
 417.15 health care programs and qualified health plan options offered through MNsure; and privacy  
 417.16 and security standards. ~~For calendar year 2014, the commissioner of human services shall~~  
 417.17 ~~ensure that the navigator program under section 256.962 provides application assistance~~  
 417.18 ~~for both qualified health plans offered through MNsure and public health care programs.~~

417.19 ~~(e)~~ (f) The board commissioner must ensure that any information provided by  
 417.20 navigators, in-person assisters, the call center, or other customer assistance portals be  
 417.21 accessible to persons with disabilities and that information provided on public health  
 417.22 care programs include information on other coverage options available to persons with  
 417.23 disabilities.

417.24 **Subd. 5. Health carrier and health plan requirements; participation.** (a)  
 417.25 ~~Beginning January 1, 2015, the board may establish certification requirements for health~~  
 417.26 ~~carriers and health plans to be offered through MNsure that satisfy federal requirements~~  
 417.27 ~~under section 1311(e)(1) of the Affordable Care Act, Public Law 111-148.~~

417.28 (b) Paragraph (a) does not apply if by June 1, 2013, the legislature enacts regulatory  
 417.29 requirements that:

417.30 (1) apply uniformly to all health carriers and health plans in the individual market;

417.31 (2) apply uniformly to all health carriers and health plans in the small group market;

417.32 and

417.33 (3) satisfy minimum federal certification requirements under section 1311(e)(1) of  
 417.34 the Affordable Care Act, Public Law 111-148.

417.35 ~~(e)~~ (a) In accordance with section 1311(e) of the Affordable Care Act, Public Law  
 417.36 111-148, the board commissioner shall establish policies and procedures for certification

418.1 and selection of health plans to be offered as qualified health plans through MNsure. The  
 418.2 ~~board commissioner~~ shall certify and select a health plan as a qualified health plan to  
 418.3 be offered through MNsure, if:

418.4 (1) the health plan meets ~~the minimum certification requirements established in~~  
 418.5 ~~paragraph (a) or the market state regulatory requirements in paragraph (b);~~

418.6 (2) the ~~board commissioner~~ determines that making the health plan available through  
 418.7 MNsure is in the interest of qualified individuals and qualified employers;

418.8 (3) the health carrier applying to offer the health plan through MNsure also applies  
 418.9 to offer health plans at each actuarial value level and service area that the health carrier  
 418.10 currently offers in the individual and small group markets; and

418.11 (4) the health carrier does not apply to offer health plans in the individual and  
 418.12 small group markets through MNsure under a separate license of a parent organization  
 418.13 or holding company under section 60D.15, that is different from what the health carrier  
 418.14 offers in the individual and small group markets outside MNsure.

418.15 ~~(d)~~ (b) In determining the interests of qualified individuals and employers under  
 418.16 paragraph ~~(e)~~ (a), clause (2), the ~~board commissioner~~ may not exclude a health plan for  
 418.17 any reason specified under section 1311(e)(1)(B) of the Affordable Care Act, Public Law  
 418.18 111-148. The ~~board commissioner~~ may consider:

418.19 (1) affordability;

418.20 (2) quality and value of health plans;

418.21 (3) promotion of prevention and wellness;

418.22 (4) promotion of initiatives to reduce health disparities;

418.23 (5) market stability and adverse selection;

418.24 (6) meaningful choices and access;

418.25 (7) alignment and coordination with state agency and private sector purchasing  
 418.26 strategies and payment reform efforts; and

418.27 (8) other criteria that the ~~board commissioner~~ determines appropriate.

418.28 ~~(e)~~ (c) For qualified health plans offered through MNsure on or after January 1, 2015  
 418.29 2017, the ~~board commissioner~~ shall establish policies and procedures ~~under paragraphs (e)~~  
 418.30 ~~and (d)~~ in accordance with this subdivision for selection of health plans to be offered as  
 418.31 qualified health plans through MNsure by February 1 of each year, beginning February 1,  
 418.32 ~~2014~~ 2016. The ~~board commissioner~~ shall consistently and uniformly apply all policies  
 418.33 and procedures and any requirements, standards, or criteria to all health carriers and  
 418.34 health plans. For any policies, procedures, requirements, standards, or criteria that are  
 418.35 defined as rules under section 14.02, subdivision 4, the ~~board commissioner~~ may use  
 418.36 the process described in subdivision 9 ~~8~~.

419.1 ~~(f) For 2014, the board shall not have the power to select health carriers and health~~  
 419.2 ~~plans for participation in MNsure. The board shall permit all health plans that meet the~~  
 419.3 ~~certification requirements under section 1311(c)(1) of the Affordable Care Act, Public~~  
 419.4 ~~Law 111-148, to be offered through MNsure.~~

419.5 ~~(g)~~ (d) Under this subdivision, the ~~board~~ commissioner shall have the power  
 419.6 to verify that health carriers and health plans are properly certified to be eligible for  
 419.7 participation in MNsure.

419.8 ~~(h)~~ (e) The ~~board~~ commissioner has the authority to decertify health carriers and  
 419.9 health plans that fail to maintain compliance with section 1311(c)(1) of the Affordable  
 419.10 Care Act, Public Law 111-148.

419.11 ~~(i)~~ (f) For qualified health plans offered through MNsure beginning January 1,  
 419.12 2015, health carriers must use the most current addendum for Indian health care providers  
 419.13 approved by the Centers for Medicare and Medicaid Services and the tribes as part of their  
 419.14 contracts with Indian health care providers. MNsure shall comply with all future changes  
 419.15 in federal law with regard to health coverage for the tribes.

419.16 Subd. 6. **Appeals.** (a) The ~~board~~ commissioner may conduct hearings, appoint  
 419.17 hearing officers, and recommend final orders related to appeals of any MNsure  
 419.18 determinations, except for those determinations identified in paragraph (d). An appeal by a  
 419.19 health carrier regarding a specific certification or selection determination made by MNsure  
 419.20 the commissioner under subdivision 5 must be conducted as a contested case proceeding  
 419.21 under chapter 14, with the report or order of the administrative law judge constituting the  
 419.22 final decision in the case, subject to judicial review under sections 14.63 to 14.69. For  
 419.23 other appeals, the ~~board~~ commissioner shall establish hearing processes which provide for  
 419.24 a reasonable opportunity to be heard and timely resolution of the appeal and which are  
 419.25 consistent with the requirements of federal law and guidance. An appealing party may be  
 419.26 represented by legal counsel at these hearings, but this is not a requirement.

419.27 (b) ~~MNsure~~ The commissioner may establish service-level agreements with state  
 419.28 agencies to conduct hearings for appeals. Notwithstanding section 471.59, subdivision  
 419.29 1, a state agency is authorized to enter into service-level agreements for this purpose  
 419.30 with ~~MNsure~~ the commissioner.

419.31 (c) For proceedings under this subdivision, MNsure may be represented by an  
 419.32 attorney who is an employee of MNsure.

419.33 (d) This subdivision does not apply to appeals of determinations where a state  
 419.34 agency hearing is available under section 256.045.

419.35 (e) An appellant aggrieved by an order of the commissioner issued in an eligibility  
 419.36 appeal, as defined in Minnesota Rules, part 7700.0101, may appeal the order to the

420.1 district court of the appellant's county of residence by serving a written copy of a notice  
420.2 of appeal upon the commissioner and any other adverse party of record within 30 days  
420.3 after the date the commissioner issued the order, the amended order, or order affirming  
420.4 the original order, and by filing the original notice and proof of service with the court  
420.5 administrator of the district court. Service may be made personally or by mail; service by  
420.6 mail is complete upon mailing; no filing fee shall be required by the court administrator in  
420.7 appeals taken pursuant to this subdivision. The commissioner shall furnish all parties to  
420.8 the proceedings with a copy of the decision and a transcript of any testimony, evidence,  
420.9 or other supporting papers from the hearing held before the appeals examiner within 45  
420.10 days after service of the notice of appeal.

420.11 (f) Any party aggrieved by the failure of an adverse party to obey an order issued  
420.12 by the commissioner may compel performance according to the order in the manner  
420.13 prescribed in sections 586.01 to 586.12.

420.14 (g) Any party may obtain a hearing at a special term of the district court by serving a  
420.15 written notice of the time and place of the hearing at least ten days prior to the date of  
420.16 the hearing. The court may consider the matter in or out of chambers, and shall take no  
420.17 new or additional evidence unless it determines that such evidence is necessary for a  
420.18 more equitable disposition of the appeal.

420.19 (h) Any party aggrieved by the order of the district court may appeal the order as in  
420.20 other civil cases. No costs or disbursements shall be taxed against any party nor shall any  
420.21 filing fee or bond be required of any party.

420.22 (i) If the commissioner or district court orders eligibility for qualified health plan  
420.23 coverage through MNsure, or eligibility for federal advance payment of premium tax  
420.24 credits or cost-sharing reductions contingent upon full payment of respective premiums,  
420.25 the premiums must be paid or provided pending appeal to the district court, Court of  
420.26 Appeals, or Supreme Court. Provision of eligibility by the commissioner pending appeal  
420.27 does not render moot the commissioner's position in a court of law.

420.28 **Subd. 7. Agreements; consultation.** (a) ~~The board~~ commissioner shall:

420.29 ~~(1) establish and maintain an agreement with the chief information officer of the~~  
420.30 ~~Office of MN.IT Services for information technology services that ensures coordination~~  
420.31 ~~with public health care programs. The board may establish and maintain agreements~~  
420.32 ~~with the chief information officer of the Office of MN.IT Services for other information~~  
420.33 ~~technology services, including an agreement that would permit MNsure to administer~~  
420.34 ~~eligibility for additional health care and public assistance programs under the authority~~  
420.35 ~~of the commissioner of human services;~~

421.1 ~~(2)~~ (1) establish and maintain an agreement with the commissioner of human  
 421.2 services for cost allocation and services regarding eligibility determinations and  
 421.3 enrollment for public health care programs that use a modified adjusted gross income  
 421.4 standard to determine program eligibility. The ~~board~~ commissioner may establish and  
 421.5 maintain an agreement with the commissioner of human services for other services;

421.6 ~~(3)~~ (2) establish and maintain an agreement with the commissioners of commerce  
 421.7 and health for services regarding enforcement of MNsure certification requirements for  
 421.8 health plans and dental plans offered through MNsure. The ~~board~~ commissioner may  
 421.9 establish and maintain agreements with the commissioners of commerce and health for  
 421.10 other services; and

421.11 ~~(4)~~ (3) establish interagency agreements to transfer funds to other state agencies for  
 421.12 their costs related to implementing and operating MNsure, excluding medical assistance  
 421.13 allocatable costs.

421.14 (b) The ~~board~~ commissioner shall consult with the commissioners of commerce and  
 421.15 health regarding the operations of MNsure.

421.16 (c) The ~~board~~ commissioner shall consult with Indian tribes and organizations  
 421.17 regarding the operation of MNsure.

421.18 (d) Beginning March 15, ~~2014~~ 2016, and each March 15 thereafter, the ~~board~~  
 421.19 commissioner shall submit a report to the chairs and ranking minority members of the  
 421.20 committees in the senate and house of representatives with primary jurisdiction over  
 421.21 commerce, health, and human services on all the agreements entered into with the chief  
 421.22 information officer of the Office of MN.IT Services, or the commissioners of human  
 421.23 services, health, or commerce in accordance with this subdivision. The report shall include  
 421.24 the agency in which the agreement is with; the time period of the agreement; the purpose  
 421.25 of the agreement; and a summary of the terms of the agreement. A copy of the agreement  
 421.26 must be submitted to the extent practicable.

421.27 Subd. 8. **Rulemaking.** ~~(a) If the board's policies, procedures, or other statements are~~  
 421.28 ~~rules, as defined in section 14.02, subdivision 4, the requirements in either paragraph (b)~~  
 421.29 ~~or (c) apply, as applicable.~~

421.30 ~~(b) Effective upon enactment until January 1, 2015:~~

421.31 ~~(1) the board shall publish notice of proposed rules in the State Register after~~  
 421.32 ~~complying with section 14.07, subdivision 2;~~

421.33 ~~(2) interested parties have 21 days to comment on the proposed rules. The board~~  
 421.34 ~~must consider comments it receives. After the board has considered all comments and~~  
 421.35 ~~has complied with section 14.07, subdivision 2, the board shall publish notice of the~~  
 421.36 ~~final rule in the State Register;~~

422.1 ~~(3) if the adopted rules are the same as the proposed rules, the notice shall state that~~  
 422.2 ~~the rules have been adopted as proposed and shall cite the prior publication. If the adopted~~  
 422.3 ~~rules differ from the proposed rules, the portions of the adopted rules that differ from the~~  
 422.4 ~~proposed rules shall be included in the notice of adoption, together with a citation to the~~  
 422.5 ~~prior State Register that contained the notice of the proposed rules; and~~

422.6 ~~(4) rules published in the State Register before January 1, 2014, take effect upon~~  
 422.7 ~~publication of the notice. Rules published in the State Register on and after January 1,~~  
 422.8 ~~2014, take effect 30 days after publication of the notice.~~

422.9 ~~(e) Beginning January 1, 2015, The board commissioner may adopt rules to~~  
 422.10 ~~implement any provisions in this chapter using the expedited rulemaking process in~~  
 422.11 ~~section 14.389.~~

422.12 ~~(d) The notice of proposed rules required in paragraph (b) must provide information~~  
 422.13 ~~as to where the public may obtain a copy of the rules. The board shall post the proposed~~  
 422.14 ~~rules on the MNsure Web site at the same time the notice is published in the State Register.~~

422.15 **Subd. 9. Dental plans.** (a) The provisions of this section that apply to health plans  
 422.16 shall apply to dental plans offered as stand-alone dental plans through MNsure, to the  
 422.17 extent practicable.

422.18 (b) A stand-alone dental plan offered through MNsure must meet all certification  
 422.19 requirements under section 1311(c)(1) of the Affordable Care Act, Public Law 111-148,  
 422.20 that are applicable to health plans, except for certification requirements that cannot be met  
 422.21 because the dental plan only covers dental benefits.

422.22 **Subd. 10. Limitations; risk-bearing.** ~~(a) The board MNsure shall not bear~~  
 422.23 ~~insurance risk or and the commissioner shall not enter into any agreement with health care~~  
 422.24 ~~providers to pay claims.~~

422.25 ~~(b) Nothing in this subdivision shall prevent MNsure from providing insurance~~  
 422.26 ~~for its employees.~~

422.27 **Subd. 11. Prohibition on other product lines.** (a) MNsure is prohibited, either  
 422.28 directly or through another agency or business partner, from certifying, selecting, or  
 422.29 offering products and policies of coverage other than qualified health plans or dental plans.

422.30 (b) This subdivision expires July 1, 2018.

422.31 Sec. 11. Minnesota Statutes 2014, section 62V.06, is amended to read:

422.32 **62V.06 DATA PRACTICES.**

422.33 Subdivision 1. **Applicability.** MNsure is a state agency for purposes of the  
 422.34 ~~Minnesota Government Data Practices Act~~ and is subject to all provisions of chapter 13,  
 422.35 in addition to the requirements contained in this section.

423.1 Subd. 2. **Definitions.** As used in this section:

423.2 (1) "individual" means an individual according to section 13.02, subdivision 8, but  
423.3 does not include a vendor of services; and

423.4 (2) "participating" means that an individual, employee, or employer is seeking, or  
423.5 has sought an eligibility determination, enrollment processing, or premium processing  
423.6 through MNsure.

423.7 Subd. 3. **General data classifications.** The following data collected, created, or  
423.8 maintained by MNsure are classified as private data on individuals, as defined in section  
423.9 13.02, subdivision 12, or nonpublic data, as defined in section 13.02, subdivision 9:

423.10 (1) data on any individual participating in MNsure;

423.11 (2) data on any individuals participating in MNsure as employees of an employer  
423.12 participating in MNsure; and

423.13 (3) data on employers participating in MNsure.

423.14 Subd. 4. **Application and certification data.** (a) Data submitted by an insurance  
423.15 producer in an application for certification to sell a health plan through MNsure, or  
423.16 submitted by an applicant seeking permission or a commission to act as a navigator or  
423.17 in-person assister, are classified as follows:

423.18 (1) at the time the application is submitted, all data contained in the application are  
423.19 private data, as defined in section 13.02, subdivision 12, or nonpublic data as defined in  
423.20 section 13.02, subdivision 9, except that the name of the applicant is public; and

423.21 (2) upon a final determination related to the application for certification by MNsure,  
423.22 all data contained in the application are public, with the exception of trade secret data as  
423.23 defined in section 13.37.

423.24 (b) Data created or maintained by a government entity as part of the evaluation of  
423.25 an application are protected nonpublic data, as defined in section 13.02, subdivision 13,  
423.26 until a final determination as to certification is made and all rights of appeal have been  
423.27 exhausted. Upon a final determination and exhaustion of all rights of appeal, these data are  
423.28 public, with the exception of trade secret data as defined in section 13.37 and data subject  
423.29 to attorney-client privilege or other protection as provided in section 13.393.

423.30 (c) If an application is denied, the public data must include the criteria used by the  
423.31 ~~board~~ commissioner to evaluate the application and the specific reasons for the denial,  
423.32 and these data must be published on the MNsure Web site.

423.33 Subd. 5. **Data sharing.** (a) ~~MNsure~~ The commissioner may share or disseminate  
423.34 data classified as private or nonpublic in subdivision 3 as follows:

423.35 (1) to the subject of the data, as provided in section 13.04;

423.36 (2) according to a court order;

424.1 (3) according to a state or federal law specifically authorizing access to the data;

424.2 (4) with other state or federal agencies, only to the extent necessary to verify the  
424.3 identity of, determine the eligibility of, process premiums for, process enrollment of, or  
424.4 investigate fraud related to an individual, employer, or employee participating in MNsure,  
424.5 provided that ~~MNsure~~ the commissioner must enter into a data-sharing agreement with the  
424.6 agency prior to sharing data under this clause; and

424.7 (5) with a nongovernmental person or entity, only to the extent necessary to verify  
424.8 the identity of, determine the eligibility of, process premiums for, process enrollment  
424.9 of, or investigate fraud related to an individual, employer, or employee participating in  
424.10 MNsure, provided that ~~MNsure~~ the commissioner must enter into a contract with the  
424.11 person or entity, as provided in section 13.05, subdivision 6 or 11, prior to disseminating  
424.12 data under this clause.

424.13 (b) ~~MNsure~~ The commissioner may share or disseminate data classified as private  
424.14 or nonpublic in subdivision 4 as follows:

424.15 (1) to the subject of the data, as provided in section 13.04;

424.16 (2) according to a court order;

424.17 (3) according to a state or federal law specifically authorizing access to the data;

424.18 (4) with other state or federal agencies, only to the extent necessary to carry out  
424.19 the functions of MNsure, provided that ~~MNsure~~ the commissioner must enter into a  
424.20 data-sharing agreement with the agency prior to sharing data under this clause; and

424.21 (5) with a nongovernmental person or entity, only to the extent necessary to carry  
424.22 out the functions of MNsure, provided that ~~MNsure~~ the commissioner must enter a  
424.23 contract with the person or entity, as provided in section 13.05, subdivision 6 or 11, prior  
424.24 to disseminating data under this clause.

424.25 (c) Sharing or disseminating data outside of MNsure in a manner not authorized by  
424.26 this subdivision is prohibited. The list of authorized dissemination and sharing contained  
424.27 in this subdivision must be included in the Tennessee warning required by section 13.04,  
424.28 subdivision 2.

424.29 ~~(d) Until July 1, 2014, state agencies must share data classified as private or~~  
424.30 ~~nonpublic on individuals, employees, or employers participating in MNsure with MNsure,~~  
424.31 ~~only to the extent such data are necessary to verify the identity of, determine the eligibility~~  
424.32 ~~of, process premiums for, process enrollment of, or investigate fraud related to a MNsure~~  
424.33 ~~participant. The agency must enter into a data-sharing agreement with MNsure prior~~  
424.34 ~~to sharing any data under this paragraph.~~



425.1 Subd. 6. **Notice and disclosures.** (a) In addition to the Tennessee warning required  
425.2 by section 13.04, subdivision 2, ~~MNsire~~ the commissioner must provide any data subject  
425.3 asked to supply private data with:

425.4 (1) a notice of rights related to the handling of genetic information, pursuant to  
425.5 section 13.386; and

425.6 (2) a notice of the records retention policy of MNsure, detailing the length of time  
425.7 MNsure will retain data on the individual and the manner in which it will be destroyed  
425.8 upon expiration of that time.

425.9 (b) All notices required by this subdivision, including the Tennessee warning, must  
425.10 be provided in an electronic format suitable for downloading or printing.

425.11 Subd. 7. **Summary data.** In addition to creation and disclosure of summary data  
425.12 derived from private data on individuals, as permitted by section 13.05, subdivision 7,  
425.13 ~~MNsire~~ the commissioner may create and disclose summary data derived from data  
425.14 classified as nonpublic under this section.

425.15 Subd. 8. **Access to data; audit trail.** (a) Only individuals with explicit authorization  
425.16 from the ~~board~~ commissioner may enter, update, or access not public data collected,  
425.17 created, or maintained by MNsure. The ability of authorized individuals to enter, update,  
425.18 or access data must be limited through the use of role-based access that corresponds to  
425.19 the official duties or training level of the individual, and the statutory authorization that  
425.20 grants access for that purpose. All queries and responses, and all actions in which data  
425.21 are entered, updated, accessed, or shared or disseminated outside of MNsure, must be  
425.22 recorded in a data audit trail. Data contained in the audit trail are public, to the extent that  
425.23 the data are not otherwise classified by this section.

425.24 The ~~board~~ commissioner shall immediately and permanently revoke the  
425.25 authorization of any individual determined to have willfully entered, updated, accessed,  
425.26 shared, or disseminated data in violation of this section, or any provision of chapter 13.  
425.27 If an individual is determined to have willfully gained access to data without explicit  
425.28 authorization from the ~~board~~ commissioner, the ~~board~~ commissioner shall forward the  
425.29 matter to the county attorney for prosecution.

425.30 (b) This subdivision shall not limit or affect the authority of the legislative auditor  
425.31 to access data needed to conduct audits, evaluations, or investigations of MNsure or the  
425.32 obligation of the ~~board~~ commissioner and MNsure employees to comply with section  
425.33 3.978, subdivision 2.

425.34 (c) This subdivision does not apply to actions taken by a MNsure participant to enter,  
425.35 update, or access data held by MNsure, if the participant is the subject of the data that  
425.36 is entered, updated, or accessed.

426.1 Subd. 9. **Sale of data prohibited.** ~~MNsure~~ The commissioner may not sell any  
 426.2 data collected, created, or maintained by MNsure, regardless of its classification, for  
 426.3 commercial or any other purposes.

426.4 Subd. 10. **Gun and firearm ownership.** ~~MNsure~~ The commissioner shall not  
 426.5 collect information that indicates whether or not an individual owns a gun or has a firearm  
 426.6 in the individual's home.

426.7 Sec. 12. Minnesota Statutes 2014, section 62V.07, is amended to read:

426.8 **62V.07 FUNDS.**

426.9 ~~(a) The MNsure account is created in the special revenue fund of the state treasury.  
 426.10 All funds received by MNsure shall be deposited in the account. Funds in the account are  
 426.11 appropriated to MNsure for the operation of MNsure. Notwithstanding section 11A.20, all  
 426.12 investment income and all investment losses attributable to the investment of the MNsure  
 426.13 account not currently needed, shall be credited to the MNsure account. All funds received  
 426.14 by MNsure shall be deposited in the state government special revenue fund.~~

426.15 ~~(b) The budget submitted to the legislature under section 16A.11 must include  
 426.16 budget information for MNsure.~~

426.17 Sec. 13. Minnesota Statutes 2014, section 62V.08, is amended to read:

426.18 **62V.08 REPORTS.**

426.19 ~~(a) MNsure~~ The commissioner shall submit a report to the legislature by January 15,  
 426.20 ~~2015~~ 2016, and each January 15 thereafter, on: (1) the performance of MNsure operations;  
 426.21 (2) meeting MNsure responsibilities; (3) an accounting of MNsure budget activities; (4)  
 426.22 practices and procedures that have been implemented to ensure compliance with data  
 426.23 practices laws, and a description of any violations of data practices laws or procedures;  
 426.24 and (5) the effectiveness of the outreach and implementation activities of MNsure in  
 426.25 reducing the rate of uninsurance.

426.26 ~~(b) MNsure~~ The commissioner must publish its administrative and operational costs  
 426.27 on a Web site to educate consumers on those costs. The information published must  
 426.28 include: (1) the amount of premiums and federal premium subsidies collected; (2) the  
 426.29 amount and source of revenue received under section 62V.05, subdivision 1, paragraph  
 426.30 (b), clause (3); (3) the amount and source of any other fees collected for purposes of  
 426.31 supporting operations; and (4) any misuse of funds as identified in accordance with section  
 426.32 3.975. The Web site must be updated at least annually.

427.1 Sec. 14. Minnesota Statutes 2014, section 245C.10, is amended by adding a  
427.2 subdivision to read:

427.3 Subd. 12. **MNsure consumer assistance partners.** The commissioner shall recover  
427.4 the cost of background studies required under section 256.962, subdivision 9, through  
427.5 a fee of no more than \$20 per study. The fees collected under this subdivision are  
427.6 appropriated to the commissioner for the purpose of conducting background studies.

427.7 Sec. 15. Minnesota Statutes 2014, section 256.962, subdivision 5, is amended to read:

427.8 Subd. 5. **Incentive program.** Beginning January 1, 2008, the commissioner shall  
427.9 establish an incentive program for ~~organizations and licensed insurance producers under~~  
427.10 ~~chapter 60K~~ community assistance partners defined under section 62V.02, subdivision  
427.11 2a, that directly identify and assist potential enrollees in filling out and submitting an  
427.12 application. For each applicant who is successfully enrolled in MinnesotaCare, or medical  
427.13 assistance, or general assistance medical care, the commissioner, within the available  
427.14 appropriation, shall pay the organization or licensed insurance producer community  
427.15 assistance partner or insurance producer if the insurance producer has completed the  
427.16 certification training program administered by the commissioner of MNsure in accordance  
427.17 with section 62V.05, subdivision 3, paragraph (j), a \$25 \$70 application assistance bonus.  
427.18 ~~The organization or licensed insurance producer may provide an applicant a gift certificate~~  
427.19 ~~or other incentive upon enrollment.~~

427.20 Sec. 16. Minnesota Statutes 2014, section 256.962, is amended by adding a subdivision  
427.21 to read:

427.22 Subd. 9. **Background studies for consumer assistance partners.** All consumer  
427.23 assistance partners, as defined in section 62V.02, subdivision 2a, are required to undergo a  
427.24 background study according to the requirements of chapter 245C.

427.25 Sec. 17. **EXPANDED ACCESS TO THE SMALL BUSINESS HEALTH CARE**  
427.26 **TAX CREDIT.**

427.27 (a) The commissioner of human services, in consultation with the commissioners  
427.28 of commerce and MNsure, shall develop a proposal to allow small employers the ability  
427.29 to receive the small business health care tax credit when the small employer pays the  
427.30 premiums on behalf of employees enrolled in either a qualified health plan offered through  
427.31 a small business health options program (SHOP) marketplace or a small group health plan  
427.32 offered outside of the small business health options program marketplace within MNsure.  
427.33 To be eligible for the tax credit, the small employer must meet the requirements under

428.1 the Affordable Care Act, except that employees may be enrolled in a small group health  
 428.2 plan product offered outside of MNsure.

428.3 (b) The commissioner of human services shall seek all federal waivers and approvals  
 428.4 necessary to implement this proposal. The commissioner shall submit a draft proposal  
 428.5 to the legislature at least 30 days before submitting a final proposal to the federal  
 428.6 government, and shall notify the legislature of any federal decision or action received  
 428.7 regarding the proposal and submitted waiver.

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

428.9 Sec. 18. **TRANSITION.**

428.10 The Department of MNsure is a continuation of MNsure as it existed on June 30,  
 428.11 2015. Minnesota Statutes, section 15.039, applies. The chief executive officer of MNsure  
 428.12 on June 30, 2015, is the acting commissioner of MNsure on July 1, 2015, unless the  
 428.13 governor designates a different acting commissioner. Any advisory committee created  
 428.14 under Minnesota Statutes 2014, section 62V.04, subdivision 13, remains in effect, and  
 428.15 current members continue to serve until the end of their terms unless the commissioner  
 428.16 terminates a committee or replaces members.

428.17 Sec. 19. **REPEALER.**

428.18 Minnesota Statutes 2014, sections 62V.04; 62V.09; and 62V.11, are repealed.

## 428.19 **ARTICLE 12**

### 428.20 **HEALTH AND HUMAN SERVICES APPROPRIATIONS**

428.21 Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

428.22 The sums shown in the columns marked "Appropriations" are appropriated to the  
 428.23 agencies and for the purposes specified in this article. The appropriations are from the  
 428.24 general fund, or another named fund, and are available for the fiscal years indicated  
 428.25 for each purpose. The figures "2016" and "2017" used in this article mean that the  
 428.26 appropriations listed under them are available for the fiscal year ending June 30, 2016, or  
 428.27 June 30, 2017, respectively. "The first year" is fiscal year 2016. "The second year" is fiscal  
 428.28 year 2017. "The biennium" is fiscal years 2016 and 2017.

428.29

428.30

428.31

428.32

**APPROPRIATIONS**  
**Available for the Year**  
**Ending June 30**  
**2016**                      **2017**



430.1 (MOE) requirements of the TANF block grant  
430.2 specified under Code of Federal Regulations,  
430.3 title 45, section 263.1, the commissioner may  
430.4 only report nonfederal money expended for  
430.5 allowable activities listed in the following  
430.6 clauses as TANF/MOE expenditures:

430.7 (1) MFIP cash, diversionary work program,  
430.8 and food assistance benefits under Minnesota  
430.9 Statutes, chapter 256J;

430.10 (2) the child care assistance programs  
430.11 under Minnesota Statutes, sections 119B.03  
430.12 and 119B.05, and county child care  
430.13 administrative costs under Minnesota  
430.14 Statutes, section 119B.15;

430.15 (3) state and county MFIP administrative  
430.16 costs under Minnesota Statutes, chapters  
430.17 256J and 256K;

430.18 (4) state, county, and tribal MFIP  
430.19 employment services under Minnesota  
430.20 Statutes, chapters 256J and 256K;

430.21 (5) expenditures made on behalf of legal  
430.22 noncitizen MFIP recipients who qualify for  
430.23 the MinnesotaCare program under Minnesota  
430.24 Statutes, chapter 256L;

430.25 (6) qualifying working family credit  
430.26 expenditures under Minnesota Statutes,  
430.27 section 290.0671; and

430.28 (7) qualifying Minnesota education credit  
430.29 expenditures under Minnesota Statutes,  
430.30 section 290.0674.

430.31 (b) The commissioner shall ensure that  
430.32 sufficient qualified nonfederal expenditures  
430.33 are made each year to meet the state's  
430.34 TANF/MOE requirements. For the activities

431.1 listed in paragraph (a), clauses (2) to  
431.2 (7), the commissioner may only report  
431.3 expenditures that are excluded from the  
431.4 definition of assistance under Code of  
431.5 Federal Regulations, title 45, section 260.31.

431.6 (c) For fiscal years beginning with state fiscal  
431.7 year 2003, the commissioner shall ensure  
431.8 that the maintenance of effort used by the  
431.9 commissioner of management and budget  
431.10 for the February and November forecasts  
431.11 required under Minnesota Statutes, section  
431.12 16A.103, contains expenditures under  
431.13 paragraph (a), clause (1), equal to at least 11  
431.14 percent in fiscal years 2016 and 2017, and  
431.15 16 percent beginning in 2018 of the total  
431.16 required under Code of Federal Regulations,  
431.17 title 45, section 263.1.

431.18 (d) The requirement in Minnesota Statutes,  
431.19 section 256.011, subdivision 3, that federal  
431.20 grants or aids secured or obtained under that  
431.21 subdivision be used to reduce any direct  
431.22 appropriations provided by law, does not  
431.23 apply if the grants or aids are federal TANF  
431.24 funds.

431.25 (e) For the federal fiscal years beginning on  
431.26 or after October 1, 2007, the commissioner  
431.27 may not claim an amount of TANF/MOE in  
431.28 excess of the 75 percent standard in Code  
431.29 of Federal Regulations, title 45, section  
431.30 263.1(a)(2), except:

431.31 (1) to the extent necessary to meet the 80  
431.32 percent standard under Code of Federal  
431.33 Regulations, title 45, section 263.1(a)(1),  
431.34 if it is determined by the commissioner

432.1 that the state will not meet the TANF work  
432.2 participation target rate for the current year;  
432.3 (2) to provide any additional amounts  
432.4 under Code of Federal Regulations, title 45,  
432.5 section 264.5, that relate to replacement of  
432.6 TANF funds due to the operation of TANF  
432.7 penalties; and

432.8 (3) to provide any additional amounts that  
432.9 may contribute to avoiding or reducing  
432.10 TANF work participation penalties through  
432.11 the operation of the excess MOE provisions  
432.12 of Code of Federal Regulations, title 45,  
432.13 section 261.43(a)(2).

432.14 For the purposes of clauses (1) to (3),  
432.15 the commissioner may supplement the  
432.16 MOE claim with working family credit  
432.17 expenditures or other qualified expenditures  
432.18 to the extent such expenditures are otherwise  
432.19 available after considering the expenditures  
432.20 allowed in this subdivision, subdivision 2,  
432.21 and subdivision 3.

432.22 (f) Notwithstanding any contrary provision  
432.23 in this article, paragraphs (a) to (e) expire  
432.24 June 30, 2019.

432.25 **Working Family Credit Expenditure**  
432.26 **as TANF/MOE.** The commissioner may  
432.27 claim as TANF maintenance of effort up to  
432.28 \$6,707,000 per year of working family credit  
432.29 expenditures in each fiscal year.

432.30 **Subd. 2. Working Family Credit to be Claimed**  
432.31 **for TANF/MOE**

432.32 The commissioner may count the following  
432.33 additional amounts of working family credit  
432.34 expenditures as TANF maintenance of effort:

432.35 (1) fiscal year 2016, \$0;



- 433.1 (2) fiscal year 2017, \$1,283,000;  
 433.2 (3) fiscal year 2018, \$0; and  
 433.3 (4) fiscal year 2019, \$0.  
 433.4 Notwithstanding any contrary provision in  
 433.5 this article, this subdivision expires June 30,  
 433.6 2019.

433.7 Subd. 3. **TANF Transfer To Federal Child Care**  
 433.8 **and Development Fund**

- 433.9 (a) The following TANF fund amounts  
 433.10 are appropriated to the commissioner for  
 433.11 purposes of MFIP/transition year child care  
 433.12 assistance under Minnesota Statutes, section  
 433.13 119B.05:

- 433.14 (1) fiscal year 2016, \$49,235,000;  
 433.15 (2) fiscal year 2017, \$51,532,000;  
 433.16 (3) fiscal year 2018, \$49,658,000; and  
 433.17 (4) fiscal year 2019, \$49,658,000.

- 433.18 (b) The commissioner shall authorize the  
 433.19 transfer of sufficient TANF funds to the  
 433.20 federal child care and development fund to  
 433.21 meet this appropriation and shall ensure that  
 433.22 all transferred funds are expended according  
 433.23 to federal child care and development fund  
 433.24 regulations.

433.25 Subd. 4. **Central Office**

- 433.26 The amounts that may be spent from this  
 433.27 appropriation for each purpose are as follows:

433.28 (a) **Operations**

433.29	<u>Appropriations by Fund</u>	
433.30	<u>General</u>	<u>114,038,000</u> <u>111,936,000</u>
433.31	<u>State Government</u>	
433.32	<u>Special Revenue</u>	<u>4,389,000</u> <u>4,149,000</u>
433.33	<u>Health Care Access</u>	<u>14,646,000</u> <u>13,751,000</u>
433.34	<u>Federal TANF</u>	<u>100,000</u> <u>100,000</u>

434.1 **MN.IT Reimbursement.** The Office  
434.2 of MN.IT Services shall reimburse the  
434.3 commissioner of human services \$7,200,000  
434.4 in fiscal year 2016 for excess billings for  
434.5 shared information technology services.

434.6 **Return on Taxpayer Investment Study.**  
434.7 \$156,000 in fiscal year 2016 and \$156,000  
434.8 in fiscal year 2017 are to the commissioner  
434.9 of human services for transfer to the  
434.10 commissioner of management and budget to  
434.11 develop and implement a return on taxpayer  
434.12 investment (ROTI) methodology using the  
434.13 Pew-MacArthur Results First framework  
434.14 to evaluate corrections and human services  
434.15 programs administered and funded by state  
434.16 and county governments. The commissioner  
434.17 shall engage and work with staff from  
434.18 Pew-MacArthur Results First and shall  
434.19 consult with representatives of other state  
434.20 agencies, counties, legislative staff, the  
434.21 commissioners of corrections and human  
434.22 services, and other commissioners of state  
434.23 agencies and stakeholders to implement the  
434.24 established methodology. The commissioner  
434.25 of management and budget shall report  
434.26 on implementation progress and make  
434.27 recommendations to the governor and  
434.28 legislature by January 31, 2017.

434.29 **Administrative Recovery; Set-Aside.** The  
434.30 commissioner may invoice local entities  
434.31 through the SWIFT accounting system as an  
434.32 alternative means to recover the actual cost  
434.33 of administering the following provisions:  
434.34 (1) Minnesota Statutes, section 125A.744,  
434.35 subdivision 3;

- 435.1 (2) Minnesota Statutes, section 245.495,  
 435.2 paragraph (b);
- 435.3 (3) Minnesota Statutes, section 256B.0625,  
 435.4 subdivision 20, paragraph (k);
- 435.5 (4) Minnesota Statutes, section 256B.0924,  
 435.6 subdivision 6, paragraph (g);
- 435.7 (5) Minnesota Statutes, section 256B.0945,  
 435.8 subdivision 4, paragraph (d); and
- 435.9 (6) Minnesota Statutes, section 256F.10,  
 435.10 subdivision 6, paragraph (b).
- 435.11 **IT Appropriations Generally.** This  
 435.12 appropriation includes funds for information  
 435.13 technology projects, services, and support.
- 435.14 Notwithstanding Minnesota Statutes,  
 435.15 section 16E.0466, funding for information  
 435.16 technology project costs shall be incorporated  
 435.17 into the service level agreement and paid  
 435.18 to the Office of MN.IT Services by the  
 435.19 Department of Human Services under  
 435.20 the rates and mechanism specified in that  
 435.21 agreement.
- 435.22 **Continued Development of MNsure**  
 435.23 **IT System.** The following amounts are  
 435.24 appropriated for transfer to the state systems  
 435.25 account under Minnesota Statutes, section  
 435.26 256.014:
- 435.27 (1) \$5,180,000 in fiscal year 2016 and  
 435.28 \$2,590,000 in fiscal year 2017 are from  
 435.29 the general fund for the state share of  
 435.30 Medicaid-allocated costs for the acceleration  
 435.31 of the MNsure IT system development  
 435.32 project. The general fund base is \$3,045,000  
 435.33 each year in fiscal years 2018 and 2019; and

436.1 (2) \$1,820,000 in fiscal year 2016 and  
 436.2 \$910,000 in fiscal year 2017 are from the  
 436.3 health care access fund for the state share  
 436.4 of MinnesotaCare-allocated costs for the  
 436.5 acceleration of the MNsure IT system  
 436.6 development project. The health care access  
 436.7 fund base is \$455,000 each year in fiscal  
 436.8 years 2018 and 2019.

436.9 **Base Level Adjustment.** The general fund  
 436.10 base is increased by \$473,000 in fiscal years  
 436.11 2018 and 2019. The health care access fund  
 436.12 base is decreased by \$455,000 in fiscal years  
 436.13 2018 and 2019.

436.14 **(b) Children and Families**

436.15	<u>Appropriations by Fund</u>		
436.16	<u>General</u>	<u>10,057,000</u>	<u>9,958,000</u>
436.17	<u>Federal TANF</u>	<u>2,582,000</u>	<u>2,582,000</u>

436.18 **Financial Institution Data Match and**  
 436.19 **Payment of Fees.** The commissioner is  
 436.20 authorized to allocate up to \$310,000 each  
 436.21 year in fiscal year 2016 and fiscal year  
 436.22 2017 from the PRISM special revenue  
 436.23 account to make payments to financial  
 436.24 institutions in exchange for performing  
 436.25 data matches between account information  
 436.26 held by financial institutions and the public  
 436.27 authority's database of child support obligors  
 436.28 as authorized by Minnesota Statutes, section  
 436.29 13B.06, subdivision 7.

436.30 Of the general fund appropriation, \$392,000  
 436.31 in fiscal year 2016 and \$453,000 in fiscal year  
 436.32 2017 are for the Ombudsperson for Families.

436.33 **Base Level Adjustment.** The general fund  
 436.34 base is increased by \$31,000 in fiscal years  
 436.35 2018 and 2019.

437.1 **(c) Health Care**437.2 Appropriations by Fund437.3 General 16,278,000 16,680,000437.4 Health Care Access 30,674,000 30,216,000

437.5 **Task Force.** Of the health care access fund  
 437.6 appropriation, \$500,000 in fiscal year 2016 is  
 437.7 for administrative services and support to the  
 437.8 Task Force on Health Care Financing. This  
 437.9 is a onetime appropriation.

437.10 **Base Level Adjustment.** The general fund  
 437.11 base is decreased by \$148,000 in fiscal year  
 437.12 2018 and is decreased by \$246,000 in fiscal  
 437.13 year 2019. The health care access fund base  
 437.14 is increased by \$1,740,000 in fiscal year  
 437.15 2018 only.

437.16 **(d) Continuing Care**437.17 Appropriations by Fund437.18 General 31,339,000 29,036,000437.19 State Government437.20 Special Revenue 125,000 125,000437.21 **Training of Direct Support Services**

437.22 **Providers.** \$250,000 in fiscal year 2017  
 437.23 is appropriated for training of individual  
 437.24 providers of direct support services as defined  
 437.25 in Minnesota Statutes, section 256B.0711,  
 437.26 subdivision 1. This appropriation is only  
 437.27 available if the labor agreement between  
 437.28 the state of Minnesota and the Service  
 437.29 Employees International Union Healthcare  
 437.30 Minnesota under Minnesota Statutes, section  
 437.31 179A.54, is approved under Minnesota  
 437.32 Statutes, sections 3.855 and 179A.22.

437.33 **Base Level Adjustment.** The general fund  
 437.34 base is increased by \$286,000 in fiscal year  
 437.35 2018 and \$226,000 in fiscal year 2019.

438.1 **(e) Chemical and Mental Health**438.2 Appropriations by Fund438.3 General 6,958,000 7,240,000438.4 Lottery Prize 160,000 163,000438.5 **Base Level Adjustment.** The general fund438.6 base is decreased by \$301,000 in fiscal year438.7 2018 and is decreased by \$353,000 in fiscal438.8 year 2019.438.9 **Subd. 5. Forecasted Programs**438.10 The amounts that may be spent from this438.11 appropriation for each purpose are as follows:438.12 **(a) MFIP/DWP**438.13 Appropriations by Fund438.14 General 90,182,000 93,975,000438.15 Federal TANF 115,102,000 119,620,000438.16 **(b) MFIP Child Care Assistance** 101,541,000 109,263,000438.17 **(c) General Assistance** 55,117,000 57,847,000438.18 **General Assistance Standard.** The438.19 commissioner shall set the monthly standard438.20 of assistance for general assistance units438.21 consisting of an adult recipient who is438.22 childless and unmarried or living apart438.23 from parents or a legal guardian at \$203.438.24 The commissioner may reduce this amount438.25 according to Laws 1997, chapter 85, article438.26 3, section 54.438.27 **Emergency General Assistance.** The438.28 amount appropriated for emergency438.29 general assistance is limited to no more438.30 than \$6,729,812 in fiscal year 2016 and438.31 \$6,729,812 in fiscal year 2017. Funds438.32 to counties shall be allocated by the438.33 commissioner using the allocation method438.34 under Minnesota Statutes, section 256D.06.

439.1	<b><u>(d) Minnesota Supplemental Aid</u></b>		<u>39,668,000</u>	<u>41,169,000</u>
439.2	<b><u>(e) Group Residential Housing</u></b>		<u>155,753,000</u>	<u>167,194,000</u>
439.3	<b><u>(f) Northstar Care for Children</u></b>		<u>41,096,000</u>	<u>46,337,000</u>
439.4	<b><u>(g) MinnesotaCare</u></b>		<u>383,064,000</u>	<u>433,941,000</u>
439.5	<u>This appropriation is from the health care</u>			
439.6	<u>access fund.</u>			
439.7	<b><u>(h) Medical Assistance</u></b>			
439.8	<u>Appropriations by Fund</u>			
439.9	<u>General</u>	<u>4,896,473,000</u>	<u>5,144,958,000</u>	
439.10	<u>Health Care Access</u>	<u>196,586,000</u>	<u>208,404,000</u>	
439.11	<b><u>Critical Access Nursing Facilities.</u></b>			
439.12	<u>\$1,500,000 each fiscal year is for critical</u>			
439.13	<u>access nursing facilities under Minnesota</u>			
439.14	<u>Statutes, section 256B.441, subdivision 63.</u>			
439.15	<b><u>Behavioral Health Services. \$1,000,000</u></b>			
439.16	<u>each fiscal year is for behavioral health</u>			
439.17	<u>services provided by hospitals identified</u>			
439.18	<u>under Minnesota Statutes, section 256.969,</u>			
439.19	<u>subdivision 2b, paragraph (a), clause (4).</u>			
439.20	<u>The increase in payments shall be made by</u>			
439.21	<u>increasing the adjustment under Minnesota</u>			
439.22	<u>Statutes, section 256.969, subdivision 2b,</u>			
439.23	<u>paragraph (e), clause (2).</u>			
439.24	<b><u>(i) Alternative Care</u></b>		<u>43,997,000</u>	<u>43,222,000</u>
439.25	<b><u>Alternative Care Transfer.</u></b> <u>Any money</u>			
439.26	<u>allocated to the alternative care program that</u>			
439.27	<u>is not spent for the purposes indicated does</u>			
439.28	<u>not cancel but must be transferred to the</u>			
439.29	<u>medical assistance account.</u>			
439.30	<b><u>(j) Chemical Dependency Treatment Fund</u></b>		<u>83,210,000</u>	<u>86,639,000</u>
439.31	<b><u>Subd. 6. Grant Programs</u></b>			

440.1 The amounts that may be spent from this  
 440.2 appropriation for each purpose are as follows:

440.3 **(a) Support Services Grants**

440.4	<u>Appropriations by Fund</u>		
440.5	<u>General</u>	<u>13,258,000</u>	<u>8,840,000</u>
440.6	<u>Federal TANF</u>	<u>96,311,000</u>	<u>96,311,000</u>

440.7 **Base Level Adjustment.** The general fund  
 440.8 base is increased by \$227,000 in fiscal years  
 440.9 2018 and 2019.

440.10 **(b) Basic Sliding Fee Child Care Assistance**  
 440.11 **Grants**

56,216,000                      56,623,000

440.12 **Basic Sliding Fee Waiting List Allocation.**

440.13 Notwithstanding Minnesota Statutes, section  
 440.14 119B.03, \$10,000,000 in fiscal year 2016  
 440.15 is to reduce the basic sliding fee program  
 440.16 waiting list as follows:

440.17 (1) The calendar year 2016 allocation shall  
 440.18 be increased to serve families on the waiting  
 440.19 list. To receive funds appropriated for this  
 440.20 purpose, a county must have:

440.21 (i) a waiting list in the most recent published  
 440.22 waiting list month;

440.23 (ii) an average of at least ten families on the  
 440.24 most recent six months of published waiting  
 440.25 list; and

440.26 (iii) total expenditures in calendar year  
 440.27 2014 that met or exceeded 80 percent of the  
 440.28 county's available final allocation.

440.29 (2) Funds shall be distributed proportionately  
 440.30 based on the average of the most recent six  
 440.31 months of published waiting lists to counties  
 440.32 that meet the criteria in clause (1).

440.33 (3) Allocations in calendar years 2017  
 440.34 and beyond shall be calculated using the



441.1 allocation formula in Minnesota Statutes,  
 441.2 section 119B.03.

441.3 (4) The guaranteed floor for calendar year  
 441.4 2017 shall be based on the revised calendar  
 441.5 year 2016 allocation.

441.6 **Base Level Adjustment.** The general fund  
 441.7 base is increased by \$2,481,000 in fiscal year  
 441.8 2018 and increased by \$2,493,000 in fiscal  
 441.9 year 2019.

441.10 **(c) Child Care Development Grants** 1,737,000 1,737,000

441.11 **(d) Child Support Enforcement Grants** 50,000 50,000

441.12 **(e) Children's Services Grants**

	<u>Appropriations by Fund</u>	
441.13		
441.14	<u>General</u>	<u>39,750,000</u> <u>39,600,000</u>
441.15	<u>Federal TANF</u>	<u>140,000</u> <u>140,000</u>

441.16 **Safe Place for Newborns.** \$150,000 from  
 441.17 the general fund in fiscal year 2016 is to  
 441.18 distribute information on the Safe Place  
 441.19 for Newborns law in Minnesota to increase  
 441.20 public awareness of the law. This is a  
 441.21 onetime appropriation.

441.22 **Child Protection.** \$22,000,000 in fiscal  
 441.23 years 2016 and 2017 is to address child  
 441.24 protection staffing and services under  
 441.25 Minnesota Statutes, section 256M.41. The  
 441.26 base for this purpose is \$12,000,000 each  
 441.27 year. \$3,000,000 in fiscal years 2016 and  
 441.28 2017 is for child protection supportive  
 441.29 services under Minnesota Statutes, section  
 441.30 256M.42.

441.31 **Title IV-E Adoption Assistance.** Additional  
 441.32 federal reimbursement to the state as a result  
 441.33 of the Fostering Connections to Success  
 441.34 and Increasing Adoptions Act's expanded

442.1 eligibility for title IV-E adoption assistance  
 442.2 are appropriated to the commissioner  
 442.3 for postadoption services, including a  
 442.4 parent-to-parent support network.

442.5 **Adoption Assistance Incentive Grants.**

442.6 Federal funds available during fiscal years  
 442.7 2016 and 2017 for adoption incentive  
 442.8 grants are appropriated to the commissioner  
 442.9 for postadoption services, including a  
 442.10 parent-to-parent support network.

442.11 **Base Level Adjustment.** The general fund  
 442.12 base is decreased by \$9,135,000 in fiscal  
 442.13 years 2018 and 2019.

442.14 **(f) Children and Community Service Grants** 57,701,000 57,701,000

442.15 **White Earth Band of Ojibwe Human**

442.16 **Services.** \$1,400,000 in fiscal year 2016 and  
 442.17 \$1,400,000 in fiscal year 2017 are for a grant  
 442.18 to the White Earth Band of Ojibwe for the  
 442.19 direct implementation and administrative  
 442.20 costs of the White Earth transfer authorized  
 442.21 under Laws 2011, First Special Session  
 442.22 chapter 9, article 9, section 18. This  
 442.23 appropriation is added to the base.

442.24 **(g) Children and Economic Support Grants** 26,423,000 26,305,000

442.25 **Healthy Eating Here at Home.** \$183,000 in  
 442.26 fiscal year 2016 and \$193,000 in fiscal year  
 442.27 2017 are for the healthy eating here at home  
 442.28 program.

442.29 **Homeless Youth Act.** Of this appropriation,  
 442.30 at least \$500,000 must be awarded to  
 442.31 providers in greater Minnesota, with at least  
 442.32 25 percent of this amount for new applicant  
 442.33 providers. The commissioner shall provide  
 442.34 outreach and technical assistance to greater

443.1 Minnesota providers and new providers to  
443.2 encourage responding to the request for  
443.3 proposals.

443.4 **Stearns County Administrative Funding.**  
443.5 \$26,000 in fiscal year 2016 and \$26,000  
443.6 in fiscal year 2017 are for a grant to  
443.7 Stearns County to provide administrative  
443.8 funding in support of a service provider  
443.9 serving veterans in Stearns County. The  
443.10 administrative funding grant may be used to  
443.11 support group residential housing services,  
443.12 corrections-related services, veteran services,  
443.13 and other social services related to the service  
443.14 provider serving veterans in Stearns County.  
443.15 This is a onetime appropriation.

443.16 **Transitional Housing.** \$321,000 in  
443.17 fiscal year 2016 is for a grant to an  
443.18 organization in Ramsey County that  
443.19 serves African American males who are  
443.20 experiencing or have experienced some  
443.21 degree of homelessness. The organization  
443.22 must provide a comprehensive program,  
443.23 including services, education, skills training,  
443.24 and housing, to transition clients from  
443.25 homelessness to stability in both housing and  
443.26 employment. The grant under this section is  
443.27 for transitional housing for up to 34 men who  
443.28 participate in the program. This is a onetime  
443.29 appropriation.

443.30 **Minnesota Food Assistance Program.**  
443.31 Unexpended funds for the Minnesota food  
443.32 assistance program for fiscal year 2016 do  
443.33 not cancel but are available for this purpose  
443.34 in fiscal year 2017.

444.1 **Base Level Adjustment.** The general fund  
 444.2 base is increased by \$183,000 in fiscal year  
 444.3 2018 and is increased by \$421,000 in fiscal  
 444.4 year 2019.

444.5 **(h) Health Care Grants**

444.6	<u>Appropriations by Fund</u>	
444.7 <u>General</u>	<u>1,932,000</u>	<u>2,904,000</u>
444.8 <u>Health Care Access</u>	<u>3,341,000</u>	<u>3,465,000</u>

444.9 **Base Level Adjustment.** The general fund  
 444.10 base is increased by \$783,000 in fiscal year  
 444.11 2018 and increased by \$354,000 in fiscal  
 444.12 year 2019.

444.13 <b><u>(i) Other Long-Term Care Grants</u></b>	<u>2,306,000</u>	<u>2,480,000</u>
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444.14 **Transition Populations.** \$1,551,000 in fiscal  
 444.15 year 2016 and \$1,725,000 in fiscal year 2017  
 444.16 are for home and community-based services  
 444.17 transition grants to assist in providing home  
 444.18 and community-based services and treatment  
 444.19 for transition populations under Minnesota  
 444.20 Statutes, section 256.478.

444.21 **Base Level Adjustment.** The general fund  
 444.22 base is decreased by \$5,000 in fiscal years  
 444.23 2018 and 2019.

444.24 <b><u>(j) Aging and Adult Services Grants</u></b>	<u>27,838,000</u>	<u>27,537,000</u>
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444.25 **Base Level Adjustment.** The general fund  
 444.26 base is increased by \$75,000 in fiscal years  
 444.27 2018 and 2019.

444.28 <b><u>(k) Deaf and Hard-of-Hearing Grants</u></b>	<u>1,875,000</u>	<u>1,875,000</u>
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444.29 <b><u>(l) Disabilities Grants</u></b>	<u>20,247,000</u>	<u>20,258,000</u>
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444.30 **(m) Adult Mental Health Grants**

444.31	<u>Appropriations by Fund</u>	
444.32 <u>General</u>	<u>69,027,000</u>	<u>69,075,000</u>
445.1 <u>Health Care Access</u>	<u>1,575,000</u>	<u>2,682,000</u>
445.2 <u>Lottery Prize</u>	<u>1,733,000</u>	<u>1,733,000</u>

445.3 **Funding Usage.** Up to 75 percent of a fiscal  
445.4 year's appropriation for adult mental health  
445.5 grants may be used to fund allocations in that  
445.6 portion of the fiscal year ending December  
445.7 31.

445.8 **Culturally Specific Mental Health**  
445.9 **Services.** \$100,000 in fiscal year 2016 is for  
445.10 grants to nonprofit organizations to provide  
445.11 resources and referrals for culturally specific  
445.12 mental health services to Southeast Asian  
445.13 veterans born before 1965 who do not qualify  
445.14 for services available to veterans formally  
445.15 discharged from the United States armed  
445.16 forces.

445.17 **Problem Gambling.** \$225,000 in fiscal year  
445.18 2016 and \$225,000 in fiscal year 2017 are  
445.19 appropriated from the lottery prize fund for a  
445.20 grant to the state affiliate recognized by the  
445.21 National Council on Problem Gambling. The  
445.22 affiliate must provide services to increase  
445.23 public awareness of problem gambling,  
445.24 education, and training for individuals and  
445.25 organizations providing effective treatment  
445.26 services to problem gamblers and their  
445.27 families, and research related to problem  
445.28 gambling.

445.29 **Sustainability Grants.** \$2,125,000 in fiscal  
445.30 year 2016 and \$2,125,000 in fiscal year 2017  
445.31 are for sustainability grants under Minnesota  
445.32 Statutes, section 256B.0622, subdivision 11.

445.33 **Base Level Adjustment.** The general fund  
445.34 base is increased by \$2,245,000 in fiscal year  
445.35 2018 and is increased by \$2,545,000 in fiscal  
446.1 year 2019. The health care access fund base

446.2 is decreased by \$1,932,000 in fiscal years

446.3 2018 and 2019.

446.4 **(n) Child Mental Health Grants**

22,421,000

22,853,000

446.5 **Services and Supports for First Episode**

446.6 **Psychosis.** \$90,000 in fiscal year 2017 is

446.7 for grants under Minnesota Statutes, section

446.8 245.4889, to mental health providers to pilot

446.9 evidence-based interventions for youth at risk

446.10 of developing or experiencing a first episode

446.11 of psychosis and for a public awareness

446.12 campaign on the signs and symptoms of

446.13 psychosis. The base for these grants is

446.14 \$160,000 in fiscal year 2018 and \$225,000 in

446.15 fiscal year 2019.

446.16 **Adverse Childhood Experiences.** \$363,000

446.17 in fiscal year 2018 and \$363,000 in fiscal year

446.18 2019 are for grants under Minnesota Statutes,

446.19 section 245.4889, to children's mental

446.20 health and family services collaboratives

446.21 for adverse childhood experiences (ACEs)

446.22 training grants and for an interactive Web site

446.23 connection to support ACEs in Minnesota.

446.24 **Funding Usage.** Up to 75 percent of a fiscal

446.25 year's appropriation for child mental health

446.26 grants may be used to fund allocations in that

446.27 portion of the fiscal year ending December

446.28 31.

446.29 **Base Level Adjustment.** The general fund

446.30 base is increased by \$235,000 in fiscal year

446.31 2018 and is increased by \$600,000 in fiscal

446.32 year 2019.

446.33 **(o) Chemical Dependency Treatment Support**

446.34 **Grants**

1,701,000

1,701,000

447.1 **Fetal Alcohol Syndrome Grants.** \$540,000

447.2 in fiscal year 2016 and \$540,000 in fiscal year

447.3 2017 are for grants to be administered by the  
 447.4 Minnesota Organization on Fetal Alcohol  
 447.5 Syndrome to provide comprehensive,  
 447.6 gender-specific, services to pregnant and  
 447.7 parenting women suspected of or known  
 447.8 to use or abuse alcohol or other drugs.  
 447.9 This appropriation is for grants to no fewer  
 447.10 than three eligible recipients. Minnesota  
 447.11 Organization on Fetal Alcohol Syndrome  
 447.12 must report to the commissioner of human  
 447.13 services annually by January 15 on the  
 447.14 grants funded by this appropriation. The  
 447.15 report must include measurable outcomes for  
 447.16 the previous year, including the number of  
 447.17 pregnant women served and the number of  
 447.18 toxic-free babies born.

447.19 Subd. 7. **DCT State-Operated Services**

447.20 **Transfer Authority for State-Operated**  
 447.21 **Services.** Money appropriated for  
 447.22 state-operated services may be transferred  
 447.23 between fiscal years of the biennium  
 447.24 with the approval of the commissioner of  
 447.25 management and budget.

447.26 The amounts that may be spent from the  
 447.27 appropriation for each purpose are as follows:

447.28 (a) **DCT State-Operated Services Mental**  
 447.29 **Health**

129,009,000

126,467,000

447.30 **Child and Adolescent Behavioral Health**  
 447.31 **Services Program Closure.** Closure of the  
 447.32 Child and Adolescent Behavioral Health  
 447.33 Services Inpatient Hospital in Willmar shall  
 447.34 not occur prior to June 30, 2016.

448.1 **Transfer.** Notwithstanding Minnesota  
 448.2 Statutes, section 246.18, subdivision 8,  
 448.3 the commissioner of human services shall

448.4 transfer \$2,000,000 in fiscal year 2017 from  
448.5 the account under Minnesota Statutes, section  
448.6 246.18, subdivision 8, in the special revenue  
448.7 fund to the general fund. This is a onetime  
448.8 transfer for repeal of never implemented  
448.9 grants for mental health specialty treatment  
448.10 services.

448.11 **Dedicated Receipts Available.** Of the  
448.12 revenue received under Minnesota Statutes,  
448.13 section 246.18, subdivision 8, paragraph  
448.14 (a), up to \$1,000,000 each year is available  
448.15 for the purposes of Minnesota Statutes,  
448.16 section 246.18, subdivision 8, paragraph (b),  
448.17 clause (1); and up to \$2,713,000 each year  
448.18 is available for the purposes of Minnesota  
448.19 Statutes, section 246.18, subdivision 8,  
448.20 paragraph (b), clause (3).

448.21 **Transfers from State-Operated Services**

448.22 **Account.** (a) If the commissioner of  
448.23 human services notifies the commissioner  
448.24 of management and budget by July 31,  
448.25 2015, that the fiscal year 2015 general  
448.26 fund expenditures exceed the general fund  
448.27 appropriation for state-operated services  
448.28 mental health to the Department of Human  
448.29 Services, notwithstanding Minnesota  
448.30 Statutes, section 246.18, subdivision 8,  
448.31 the commissioner of human services,  
448.32 with the approval of the commissioner of  
448.33 management and budget, shall transfer up  
448.34 to \$1,000,000 in fiscal year 2015 from the  
448.35 account under Minnesota Statutes, section  
448.36 246.18, subdivision 8, in the special revenue  
449.1 fund to the general fund. The amount  
449.2 transferred under this paragraph must  
449.3 not exceed the amount of the fiscal year



449.4 2015 negative balance in the general fund  
449.5 appropriation for state-operated services  
449.6 mental health to the Department of Human  
449.7 Services. The amount transferred under  
449.8 this paragraph, up to \$1,000,000 in fiscal  
449.9 year 2015, is appropriated from the general  
449.10 fund to the commissioner of human services  
449.11 for state-operated services mental health  
449.12 expenditures. This paragraph is effective the  
449.13 day following final enactment and expires  
449.14 on October 1, 2015. Any amount transferred  
449.15 under this paragraph that is not expended  
449.16 by September 30, 2015, shall cancel to  
449.17 the account from which the amount was  
449.18 transferred.

449.19 (b) If the commissioner of human services  
449.20 notifies the commissioner of management  
449.21 and budget by July 31, 2015, that the  
449.22 balance in fiscal year 2015 in the Minnesota  
449.23 state-operated community services fund is a  
449.24 negative amount, notwithstanding Minnesota  
449.25 Statutes, section 246.18, subdivision 8, the  
449.26 commissioner of human services, with the  
449.27 approval of the commissioner of management  
449.28 and budget, shall transfer up to \$3,200,000  
449.29 in fiscal year 2015 from the account  
449.30 under Minnesota Statutes, section 246.18,  
449.31 subdivision 8, in the special revenue fund  
449.32 to the Minnesota state-operated community  
449.33 services fund. The amount transferred under  
449.34 this paragraph must not exceed the amount  
449.35 of the fiscal year 2015 negative balance in  
449.36 the Minnesota state-operated community  
450.1 services fund. This paragraph is effective the  
450.2 day following final enactment and expires  
450.3 on October 1, 2015. Any amount transferred

450.4 under this paragraph that is not expended  
 450.5 by September 30, 2015, shall cancel to  
 450.6 the account from which the amount was  
 450.7 transferred.

450.8 **Appropriations Retroactive to Fiscal Year**  
 450.9 **2015.** If the commissioner of human services  
 450.10 notifies the commissioner of management and  
 450.11 budget by July 31, 2015, that the fiscal year  
 450.12 2015 general fund expenditures exceed the  
 450.13 general fund appropriation for state-operated  
 450.14 services mental health to the Department of  
 450.15 Human Services, up to \$5,000,000 of this  
 450.16 appropriation in fiscal year 2016 may be  
 450.17 used in fiscal year 2015 for state-operated  
 450.18 services mental health expenditures. The  
 450.19 commissioner of human services must  
 450.20 report to the commissioner of management  
 450.21 and budget the purpose and amount of any  
 450.22 expenditures under this paragraph, and the  
 450.23 commissioner of management and budget  
 450.24 must approve the total amount attributable to  
 450.25 this paragraph. This paragraph is effective  
 450.26 the day following final enactment and expires  
 450.27 on October 1, 2015.

450.28 **Base Level Adjustment.** The general fund  
 450.29 base is decreased by \$1,074,000 in fiscal  
 450.30 years 2018 and 2019.

450.31 **(b) DCT State-Operated Services Enterprise**  
 450.32 **Services**

8,058,000

5,615,000

450.33 **Transfers from Consolidated Chemical**  
 450.34 **Dependency Treatment Fund.** (a) If the  
 450.35 commissioner of human services notifies the  
 450.36 commissioner of management and budget by  
 451.1 July 31, 2015, that the balance in fiscal year  
 451.2 2015 in the community addiction recovery  
 451.3 enterprise fund is a negative amount,

451.4 notwithstanding Minnesota Statutes, section  
451.5 254B.06, subdivision 1, the commissioner  
451.6 of human services, with the approval of the  
451.7 commissioner of management and budget,  
451.8 shall transfer \$2,000,000 in fiscal year 2015  
451.9 from the consolidated chemical dependency  
451.10 treatment fund account in the special revenue  
451.11 fund to the community addiction recovery  
451.12 enterprise fund. The amount transferred  
451.13 under this paragraph must not exceed the  
451.14 amount of the fiscal year 2015 negative  
451.15 balance in the community addiction recovery  
451.16 enterprise fund. This paragraph is effective  
451.17 the day following final enactment and expires  
451.18 on October 1, 2015. Any amount transferred  
451.19 under this paragraph that is not expended  
451.20 by September 30, 2015, shall cancel to  
451.21 the account from which the amount was  
451.22 transferred.

451.23 (b) If the commissioner of human services  
451.24 notifies the commissioner of management  
451.25 and budget by July 31, 2015, that the  
451.26 fiscal year 2015 general fund expenditures  
451.27 exceed the general fund appropriation  
451.28 for state-operated services mental health  
451.29 to the Department of Human Services,  
451.30 notwithstanding Minnesota Statutes, section  
451.31 254B.06, subdivision 1, the commissioner  
451.32 of human services, with the approval of the  
451.33 commissioner of management and budget,  
451.34 shall transfer \$1,500,000 in fiscal year 2015  
451.35 from the consolidated chemical dependency  
451.36 treatment fund account in the special revenue  
452.1 fund to the general fund. \$1,500,000 in  
452.2 fiscal year 2015 is appropriated from the  
452.3 general fund to the commissioner of human

452.4 services for state-operated services mental  
 452.5 health expenditures. The amount transferred  
 452.6 under this paragraph must not exceed the  
 452.7 amount of the fiscal year 2015 negative  
 452.8 balance in the general fund appropriation  
 452.9 for state-operated services mental health to  
 452.10 the Department of Human Services. This  
 452.11 paragraph is effective the day following final  
 452.12 enactment and expires on October 1, 2015.  
 452.13 Any amount transferred under this paragraph  
 452.14 that is not expended by September 30, 2015,  
 452.15 shall cancel to the account from which the  
 452.16 amount was transferred.

452.17 **(c) DCT State-Operated Services Minnesota**  
 452.18 **Security Hospital**

81,821,000

83,233,000

452.19 **Base Level Adjustment.** The general fund  
 452.20 base is increased by \$17,000 in fiscal year  
 452.21 2018 and \$34,000 in fiscal year 2019.

452.22 **Subd. 8. DCT Minnesota Sex Offender**  
 452.23 **Program**

86,473,000

89,464,000

452.24 **Individual Evaluations of MSOP Client.**  
 452.25 \$1,487,000 in fiscal year 2016 and \$1,487,000  
 452.26 in fiscal year 2017 are to conduct biennial  
 452.27 individual evaluations of MSOP clients on  
 452.28 statutory criteria for reduction in custody.  
 452.29 This appropriation is added to the base.

452.30 **Transfer Authority for Minnesota Sex**  
 452.31 **Offender Program.** Money appropriated  
 452.32 for the Minnesota sex offender program  
 452.33 may be transferred between fiscal years  
 452.34 of the biennium with the approval of the  
 452.35 commissioner of management and budget.

453.1 **Limited Carryforward Allowed.**  
 453.2 Notwithstanding any contrary provision  
 453.3 in this article, of this appropriation, up to

453.4 \$875,000 in fiscal year 2016 and \$2,625,000  
 453.5 in fiscal year 2017 are available until June  
 453.6 30, 2019.

453.7 **Minnesota Sex Offender Program.** Any  
 453.8 funds from the appropriation made by Laws  
 453.9 2014, chapter 312, article 30, section 2,  
 453.10 subdivision 6, that are not used for payment  
 453.11 of court-ordered costs in compliance with  
 453.12 the United States District Court order of  
 453.13 February 20, 2014, in the matter of Karsjens  
 453.14 et al. v. Jesson et al., including any funds  
 453.15 returned by the court that had been deposited  
 453.16 with the court but not spent, may be used by  
 453.17 the commissioner of human services to offset  
 453.18 past and future litigation expenses in the  
 453.19 same matter and to comply with any future  
 453.20 orders of the United States District Court.

453.21 **Base Level Adjustment.** The general fund  
 453.22 base is decreased by \$2,625,000 in fiscal  
 453.23 years 2018 and 2019.

453.24 **Subd. 9. Technical Activities** 59,371,000 61,668,000

453.25 This appropriation is from the federal TANF  
 453.26 fund.

453.27 **Base Level Adjustment.** The TANF fund  
 453.28 appropriation is decreased by \$1,874,000 in  
 453.29 fiscal years 2018 and 2019.

453.30 **Sec. 3. COMMISSIONER OF HEALTH**

453.31 **Subdivision 1. Total Appropriation** **\$ 185,600,000 \$ 187,657,000**

453.32 Appropriations by Fund

	<u>2016</u>	<u>2017</u>
453.33 <u>General</u>	<u>95,339,000</u>	<u>98,168,000</u>
454.1 <u>State Government</u>		
454.2 <u>Special Revenue</u>	<u>55,524,000</u>	<u>55,318,000</u>
454.3 <u>Health Care Access</u>	<u>34,737,000</u>	<u>34,171,000</u>

454.4 The amounts that may be spent for each  
 454.5 purpose are specified in the following  
 454.6 subdivisions.

454.7 **Subd. 2. Health Improvement**

454.8	<u>Appropriations by Fund</u>	
454.9	<u>General</u>	<u>74,573,000</u> <u>75,795,000</u>
454.10	<u>State Government</u>	
454.11	<u>Special Revenue</u>	<u>6,264,000</u> <u>6,182,000</u>
454.12	<u>Health Care Access</u>	<u>34,737,000</u> <u>34,171,000</u>

454.13 **Violence Against Asian Women Working**

454.14 **Group.** \$200,000 in fiscal year 2016 from  
 454.15 the general fund is for the working group on  
 454.16 violence against Asian women and children.

454.17 **Poison Information Center Grants.**

454.18 \$750,000 in fiscal year 2016 and \$750,000 in  
 454.19 fiscal year 2017 from the general fund are  
 454.20 for regional poison information center grants  
 454.21 under Minnesota Statutes, section 145.93.

454.22 **Early Dental Prevention Grants.** \$172,000

454.23 in fiscal year 2016 and \$140,000 in fiscal year  
 454.24 2017 are for the development and distribution  
 454.25 of the early dental prevention initiative under  
 454.26 Minnesota Statutes, section 144.3875.

454.27 **International Medical Graduate**

454.28 **Assistance Program.** (a) \$500,000 in fiscal  
 454.29 year 2016 and \$500,000 in fiscal year 2017  
 454.30 are from the health care access fund for  
 454.31 the grant programs and necessary contracts  
 454.32 under Minnesota Statutes, section 144.1911,  
 454.33 subdivisions 3, paragraph (a), clause (4), and  
 454.34 4 and 5. The commissioner may use up to  
 454.35 \$133,000 per year of the appropriation for  
 455.1 international medical graduate assistance  
 455.2 program administration duties in Minnesota  
 455.3 Statutes, section 144.1911, subdivisions

455.4 3, 9, and 10, and for administering the  
455.5 grant programs under Minnesota Statutes,  
455.6 section 144.1911, subdivisions 4, 5,  
455.7 and 6. The commissioner shall develop  
455.8 recommendations for any additional funding  
455.9 required for initiatives needed to achieve the  
455.10 objectives of Minnesota Statutes, section  
455.11 144.1911. The commissioner shall report the  
455.12 funding recommendations to the legislature  
455.13 by January 15, 2016, in the report required  
455.14 under Minnesota Statutes, section 144.1911,  
455.15 subdivision 10. The base for this purpose is  
455.16 \$1,000,000 in fiscal years 2018 and 2019.

455.17 (b) \$500,000 in fiscal year 2016 and  
455.18 \$500,000 in fiscal year 2017 are from the  
455.19 health care access fund for transfer to the  
455.20 revolving international medical graduate  
455.21 residency account established in Minnesota  
455.22 Statutes, section 144.1911, subdivision 6.  
455.23 This is a onetime appropriation.

455.24 **Somali Women's Health Pilot Program.**

455.25 (a) The commissioner of health shall  
455.26 establish a pilot program between one or  
455.27 more federally qualified health centers, as  
455.28 defined under Minnesota Statutes, section  
455.29 145.9269, Isuroon, a Somali-based women's  
455.30 organization, and the Minnesota Evaluation  
455.31 Studies Institute, to develop a promising  
455.32 strategy to address the preventative and  
455.33 primary health care needs of, and address  
455.34 health inequities experienced by, first  
455.35 generation Somali women. The pilot  
455.36 program must collaboratively develop a  
456.1 patient flow process for first generation  
456.2 Somali women by:

456.3 (1) addressing and identifying clinical and  
456.4 cultural barriers to Somali women accessing  
456.5 preventative and primary care, including,  
456.6 but not limited to, cervical and breast cancer  
456.7 screenings;

456.8 (2) developing a culturally appropriate health  
456.9 curriculum for Somali women based on  
456.10 the outcomes from the community-based  
456.11 participatory research report "Cultural  
456.12 Traditions and the Reproductive Health  
456.13 of Somali Refugees and Immigrants" to  
456.14 increase the health literacy of Somali women  
456.15 and develop culturally specific health care  
456.16 information; and

456.17 (3) training the federally qualified health  
456.18 center's providers and staff to enhance  
456.19 provider and staff cultural competence  
456.20 regarding the cultural barriers, including  
456.21 female genital cutting.

456.22 (b) The pilot program must develop a process  
456.23 that results in increased screening rates  
456.24 for cervical and breast cancer and can be  
456.25 replicated by other providers serving ethnic  
456.26 minorities. The pilot program must conduct  
456.27 an evaluation of the new patient flow process  
456.28 used by Somali women to access federally  
456.29 qualified health centers services.

456.30 (c) The pilot program must report the  
456.31 outcomes to the commissioner by June 30,  
456.32 2017.

456.33 (d) \$125,000 in fiscal year 2016 and  
456.34 \$125,000 in fiscal year 2017 are for the  
456.35 Somali women's health pilot program. This  
457.1 appropriation is available until June 30,  
457.2 2017. This is a onetime appropriation.



457.3 **Menthol Cigarette Study in the**  
457.4 **African-American Community.** (a) The  
457.5 commissioner of health, in consultation with  
457.6 representatives of the African-American  
457.7 community and other interested stakeholders,  
457.8 shall evaluate the current attitudes and  
457.9 beliefs related to menthol-flavored cigarette  
457.10 usage among African-Americans in  
457.11 Minnesota and make recommendations  
457.12 based on this evaluation on ways to reduce  
457.13 the disproportionately high usage of  
457.14 cigarettes by African-Americans, especially  
457.15 the use of menthol-flavored cigarettes,  
457.16 as well as the disproportionate harm  
457.17 tobacco use causes in that community.  
457.18 The commissioner shall engage members  
457.19 of the African-American community  
457.20 and community-based organizations in  
457.21 conducting the evaluation and creating  
457.22 recommendations on how to address tobacco  
457.23 use within the African-American community.  
457.24 (b) The commissioner shall submit the results  
457.25 of the evaluation and the recommendations  
457.26 to the chairs and ranking minority members  
457.27 of the senate and house of representatives  
457.28 health and human services policy and finance  
457.29 committees by January 15, 2016.  
457.30 The health care access fund base for the  
457.31 statewide health improvement program is  
457.32 reduced by \$200,000 in fiscal year 2016 and  
457.33 \$200,000 from the health care access in fiscal  
457.34 year 2016 is appropriated for this study.  
458.1 **Targeted Home Visiting System.** (a)  
458.2 \$75,000 in fiscal year 2016 is for the  
458.3 commissioner of health, in consultation

458.4 with the commissioners of human services  
458.5 and education, community health boards,  
458.6 tribal nations, and other home visiting  
458.7 stakeholders, to design baseline training  
458.8 for new home visitors to ensure statewide  
458.9 coordination across home visiting programs.

458.10 (b) \$575,000 in fiscal year 2016 and  
458.11 \$2,000,000 fiscal year 2017 are to provide  
458.12 grants to community health boards and  
458.13 tribal nations for start-up grants for new  
458.14 nurse-family partnership programs and  
458.15 for grants to expand existing programs  
458.16 to serve first-time mothers, prenatally by  
458.17 28 weeks gestation until the child is two  
458.18 years of age, who are eligible for medical  
458.19 assistance under Minnesota Statutes, chapter  
458.20 256B, or the federal Special Supplemental  
458.21 Nutrition Program for Women, Infants, and  
458.22 Children. The commissioner shall award  
458.23 grants to community health boards or tribal  
458.24 nations in metropolitan and rural areas of  
458.25 the state. Priority for all grants shall be  
458.26 given to nurse-family partnership programs  
458.27 that provide services through a Minnesota  
458.28 health care program-enrolled provider that  
458.29 accepts medical assistance. Additionally,  
458.30 priority for grants to rural areas shall be  
458.31 given to community health boards and tribal  
458.32 nations that expand services within regional  
458.33 partnerships that provide the nurse-family  
458.34 partnership program. Funding available  
458.35 under this paragraph may only be used to  
458.36 supplement, not to replace, funds being used  
459.1 for nurse-family partnership home visiting  
459.2 services as of June 30, 2015.

- 459.3 **Local and Tribal Public Health Grants. (a)**
- 459.4 \$894,000 in fiscal year 2016 and \$894,000 in
- 459.5 fiscal year 2017 are for an increase in local
- 459.6 public health grants for community health
- 459.7 boards under Minnesota Statutes, section
- 459.8 145A.131, subdivision 1, paragraph (e).
- 459.9 **(b) \$106,000 in fiscal year 2016 and \$106,000**
- 459.10 in fiscal year 2017 are for an increase in
- 459.11 special grants to tribal governments under
- 459.12 Minnesota Statutes, section 145A.14,
- 459.13 subdivision 2a.
- 459.14 **Family Planning Special Projects.**
- 459.15 \$1,000,000 in fiscal year 2016 and
- 459.16 \$1,000,000 in fiscal year 2017 from the
- 459.17 general fund are for family planning special
- 459.18 project grants under Minnesota Statutes,
- 459.19 section 145.925.
- 459.20 **Safe Harbor for Sexually Exploited Youth.**
- 459.21 \$700,000 in fiscal year 2016 and \$700,000 in
- 459.22 fiscal year 2017 from the general fund are
- 459.23 for the safe harbor program under Minnesota
- 459.24 Statutes, sections 145.4716 to 145.4718.
- 459.25 Funds shall be used for grants to increase
- 459.26 the number of regional navigators; training
- 459.27 for professionals who engage with exploited
- 459.28 or at-risk youth; implementing statewide
- 459.29 protocols and best practices for effectively
- 459.30 identifying, interacting with, and referring
- 459.31 sexually exploited youth to appropriate
- 459.32 resources; and program operating costs.
- 459.33 **Health Care Grants for Uninsured**
- 459.34 **Individuals. (a) \$125,000 of the general fund**
- 459.35 appropriation in fiscal years 2016 and 2017
- 460.1 is for dental provider grants in Minnesota
- 460.2 Statutes, section 145.929, subdivision 1.

460.3 (b) \$437,500 of the general fund  
460.4 appropriation in fiscal years 2016 and 2017 is  
460.5 for community mental health program grants  
460.6 in Minnesota Statutes, section 145.929,  
460.7 subdivision 2.

460.8 (c) \$1,500,000 of the general fund  
460.9 appropriation in fiscal years 2016 and 2017 is  
460.10 for the emergency medical assistance outlier  
460.11 grant program in Minnesota Statutes, section  
460.12 145.929, subdivision 3.

460.13 (d) \$437,500 of the general fund  
460.14 appropriation in fiscal years 2016 and 2017  
460.15 is for community health center grants under  
460.16 Minnesota Statutes, section 145.9269. A  
460.17 community health center that receives a grant  
460.18 from this appropriation is not eligible for a  
460.19 grant under paragraph (b).

460.20 (e) The commissioner may use up to \$25,000  
460.21 of the appropriations for health care grants  
460.22 for uninsured individuals in fiscal years 2016  
460.23 and 2017 for grant administration.

460.24 **Home Visiting and Nutritional Services.**  
460.25 \$3,579,000 in fiscal year 2016 and  
460.26 \$3,579,000 in fiscal year 2017 from the  
460.27 general fund are for home visiting and  
460.28 nutritional services listed under Minnesota  
460.29 Statutes, section 145.882, subdivision 7,  
460.30 clauses (6) and (7). Funds must be distributed  
460.31 to community health boards according to  
460.32 Minnesota Statutes, section 145A.131,  
460.33 subdivision 1, paragraph (a).

460.34 **Infant Mortality.** \$2,000,000 in fiscal year  
460.35 2016 and \$2,000,000 in fiscal year 2017 from  
461.1 the general fund are for decreasing racial and  
461.2 ethnic disparities in infant mortality rates

461.3 under Minnesota Statutes, section 145.928,  
461.4 subdivision 7.

461.5 **Family Home Visiting.** (a) \$4,978,000 in  
461.6 fiscal year 2016 and \$4,978,000 in fiscal  
461.7 year 2017 from the general fund are for  
461.8 the family home visiting grant program  
461.9 according to Minnesota Statutes, section  
461.10 145A.17. \$4,000,000 of the funding must  
461.11 be distributed to community health boards  
461.12 according to Minnesota Statutes, section  
461.13 145A.131, subdivision 1, paragraph (a).  
461.14 \$978,000 of the funding must be distributed  
461.15 to tribal governments based on Minnesota  
461.16 Statutes, section 145A.14, subdivision 2a.

461.17 (b) The commissioner may use up to 6.23  
461.18 percent of the funds appropriated each fiscal  
461.19 year to conduct the ongoing evaluations  
461.20 required under Minnesota Statutes, section  
461.21 145A.17, subdivision 7, and training and  
461.22 technical assistance as required under  
461.23 Minnesota Statutes, section 145A.17,  
461.24 subdivisions 4 and 5.

461.25 **Health Professional Loan Forgiveness.**  
461.26 \$3,131,000 in fiscal year 2016 and \$3,131,000  
461.27 in fiscal year 2017 from the general fund  
461.28 are for the purposes of Minnesota Statutes,  
461.29 section 144.1501. Of this appropriation, the  
461.30 commissioner may use up to \$131,000 each  
461.31 year to administer the program.

461.32 **Minnesota Stroke System.** \$350,000 in  
461.33 fiscal year 2016 and \$350,000 in fiscal  
461.34 year 2017 from the general fund are for the  
461.35 Minnesota stroke system.

462.1 **Family Planning Grants.** \$1,156,000 in  
462.2 fiscal year 2016 and \$1,156,000 in fiscal year

462.3 2017 from the general fund are for family  
 462.4 planning grants under Minnesota Statutes,  
 462.5 section 145.925.

462.6 **Regional Grants.** \$703,000 in fiscal year  
 462.7 2016 and \$701,000 in fiscal year 2017  
 462.8 from the general fund are for the regional  
 462.9 emergency medical services programs. Of  
 462.10 this amount, \$118,000 each fiscal year may be  
 462.11 used for operating expenses of the program.

462.12 **Prevention of Violence in Health Care.**  
 462.13 \$50,000 in fiscal year 2016 is to continue the  
 462.14 prevention of violence in health care program  
 462.15 and creating violence prevention resources  
 462.16 for hospitals and other health care providers  
 462.17 to use in training their staff on violence  
 462.18 prevention. This is a onetime appropriation  
 462.19 and is available until June 30, 2017.

462.20 **Base Level Adjustments.** The general fund  
 462.21 base is decreased by \$175,000 in fiscal year  
 462.22 2018 and \$125,000 in fiscal year 2019. The  
 462.23 state government special revenue fund base  
 462.24 is increased by \$33,000 in fiscal year 2018.

462.25 The health care access fund base is increased  
 462.26 by \$610,000 in fiscal year 2018 and \$23,000  
 462.27 in fiscal year 2019.

462.28 **Subd. 3. Health Protection**

	<u>Appropriations by Fund</u>	
462.29		
462.30	<u>General</u>	<u>12,556,000</u> <u>14,149,000</u>
462.31	<u>State Government</u>	
462.32	<u>Special Revenue</u>	<u>49,260,000</u> <u>49,136,000</u>

462.33 **Base Level Adjustments.** The state  
 462.34 government special revenue fund base is  
 463.1 increased by \$262,000 in fiscal year 2018 and  
 463.2 is increased by \$235,000 in fiscal year 2019.

463.3 **Subd. 4. Administrative Support Services**                      8,210,000                      8,224,000

463.4 **Sec. 4. HEALTH-RELATED BOARDS**

463.5	<b><u>Subdivision 1. Total Appropriation</u></b>	<b><u>\$ 19,707,000</u></b>	<b><u>\$ 19,597,000</u></b>
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463.6 This appropriation is from the state  
 463.7 government special revenue fund. The  
 463.8 amounts that may be spent for each purpose  
 463.9 are specified in the following subdivisions.

463.10	<b><u>Subd. 2. Board of Chiropractic Examiners</u></b>	<u>507,000</u>	<u>513,000</u>
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463.11	<b><u>Subd. 3. Board of Dentistry</u></b>	<u>2,192,000</u>	<u>2,206,000</u>
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463.12 This appropriation includes \$864,000 in fiscal  
 463.13 year 2016 and \$878,000 in fiscal year 2017  
 463.14 for the health professional services program.

463.15	<b><u>Subd. 4. Board of Dietetics and Nutrition</u></b>		
463.16	<b><u>Practice</u></b>	<u>113,000</u>	<u>115,000</u>

463.17	<b><u>Subd. 5. Board of Marriage and Family</u></b>		
463.18	<b><u>Therapy</u></b>	<u>234,000</u>	<u>237,000</u>

463.19	<b><u>Subd. 6. Board of Medical Practice</u></b>	<u>3,933,000</u>	<u>3,962,000</u>
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463.20	<b><u>Subd. 7. Board of Nursing</u></b>	<u>4,189,000</u>	<u>4,243,000</u>
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463.21	<b><u>Subd. 8. Board of Nursing Home</u></b>		
463.22	<b><u>Administrators</u></b>	<u>2,365,000</u>	<u>2,062,000</u>

463.23 **Administrative Services Unit - Operating**

463.24 **Costs.** Of this appropriation, \$1,482,000

463.25 in fiscal year 2016 and \$1,497,000 in

463.26 fiscal year 2017 are for operating costs

463.27 of the administrative services unit. The

463.28 administrative services unit may receive

463.29 and expend reimbursements for services

463.30 performed by other agencies.

463.31 **Administrative Services Unit - Volunteer**

463.32 **Health Care Provider Program.** Of this

463.33 appropriation, \$150,000 in fiscal year 2016

464.1 and \$150,000 in fiscal year 2017 are to pay

464.2 for medical professional liability coverage

464.3 required under Minnesota Statutes, section

464.4 214.40.

464.5 **Administrative Services Unit - Retirement**

464.6 **Costs.** Of this appropriation, \$320,000 in  
 464.7 fiscal year 2016 is a onetime appropriation  
 464.8 to the administrative services unit to pay for  
 464.9 the retirement costs of health-related board  
 464.10 employees. This funding may be transferred  
 464.11 to the health board incurring the retirement  
 464.12 costs. These funds are available either year  
 464.13 of the biennium.

464.14 **Administrative Services Unit - Contested**

464.15 **Cases and Other Legal Proceedings.** Of  
 464.16 this appropriation, \$200,000 in fiscal year  
 464.17 2016 and \$200,000 in fiscal year 2017 are  
 464.18 for costs of contested case hearings and other  
 464.19 unanticipated costs of legal proceedings  
 464.20 involving health-related boards funded  
 464.21 under this section. Upon certification by a  
 464.22 health-related board to the administrative  
 464.23 services unit that the costs will be incurred  
 464.24 and that there is insufficient money available  
 464.25 to pay for the costs out of money currently  
 464.26 available to that board, the administrative  
 464.27 services unit is authorized to transfer money  
 464.28 from this appropriation to the board for  
 464.29 payment of those costs with the approval  
 464.30 of the commissioner of management and  
 464.31 budget. The commissioner of management  
 464.32 and budget must require any board that  
 464.33 has an unexpended balance for an amount  
 464.34 transferred under this paragraph to transfer  
 464.35 the unexpended amount to the administrative  
 465.1 services unit to be deposited in the state  
 465.2 government special revenue fund.

465.3	<b><u>Subd. 9. Board of Optometry</u></b>	<u>138,000</u>	<u>143,000</u>
465.4	<b><u>Subd. 10. Board of Pharmacy</u></b>	<u>2,847,000</u>	<u>2,888,000</u>



465.5	<u>Subd. 11. Board of Physical Therapy</u>		<u>354,000</u>	<u>359,000</u>
465.6	<u>Subd. 12. Board of Podiatry</u>		<u>78,000</u>	<u>79,000</u>
465.7	<u>Subd. 13. Board of Psychology</u>		<u>874,000</u>	<u>884,000</u>
465.8	<u>Subd. 14. Board of Social Work</u>		<u>1,141,000</u>	<u>1,155,000</u>
465.9	<u>Subd. 15. Board of Veterinary Medicine</u>		<u>262,000</u>	<u>265,000</u>
465.10	<u>Subd. 16. Board of Behavioral Health and</u>			
465.11	<u>Therapy</u>		<u>480,000</u>	<u>486,000</u>
465.12	<u>Sec. 5. EMERGENCY MEDICAL SERVICES</u>			
465.13	<u>REGULATORY BOARD</u>	<u>\$</u>	<u>2,287,000</u>	<u>\$ 2,420,000</u>
465.14	<u>Cooper/Sams Volunteer Ambulance</u>			
465.15	<u>Program. \$700,000 in fiscal year 2016 and</u>			
465.16	<u>\$700,000 in fiscal year 2017 are for the</u>			
465.17	<u>Cooper/Sams volunteer ambulance program</u>			
465.18	<u>under Minnesota Statutes, section 144E.40.</u>			
465.19	<u>(a) Of this amount, \$611,000 in fiscal year</u>			
465.20	<u>2016 and \$611,000 in fiscal year 2017</u>			
465.21	<u>are for the ambulance service personnel</u>			
465.22	<u>longevity award and incentive program under</u>			
465.23	<u>Minnesota Statutes, section 144E.40.</u>			
465.24	<u>(b) Of this amount, \$89,000 in fiscal year</u>			
465.25	<u>2016 and \$89,000 in fiscal year 2017 are</u>			
465.26	<u>for the operations of the ambulance service</u>			
465.27	<u>personnel longevity award and incentive</u>			
465.28	<u>program under Minnesota Statutes, section</u>			
465.29	<u>144E.40.</u>			
465.30	<u>Ambulance Training Grant. \$361,000 in</u>			
465.31	<u>fiscal year 2016 and \$361,000 in fiscal year</u>			
465.32	<u>2017 are for training grants.</u>			
466.1	<u>EMSRB Board Operations. \$1,226,000 in</u>			
466.2	<u>fiscal year 2016 and \$1,360,000 in fiscal year</u>			
466.3	<u>2017 are for board operations.</u>			
466.4	<u>Sec. 6. COUNCIL ON DISABILITY</u>	<u>\$</u>	<u>730,000</u>	<u>\$ 707,000</u>

466.5 **Staffing and Technology.** \$78,000 in fiscal  
 466.6 years 2016 and 2017 is for one staff person.  
 466.7 \$30,000 in fiscal year 2016 only is for a  
 466.8 computer system upgrade.

466.9 **Sec. 7. OMBUDSMAN FOR MENTAL**  
 466.10 **HEALTH AND DEVELOPMENTAL**  
 466.11 **DISABILITIES**

**\$ 2,097,000 \$ 2,217,000**

466.12 **Sec. 8. MNSURE**

**\$ 94,026,000 \$ 42,865,000**

466.13 This appropriation is from the state  
 466.14 government special revenue fund.

466.15 **Base Level Adjustment.** The state  
 466.16 government special revenue fund base is  
 466.17 decreased by \$148,000 in fiscal years 2018  
 466.18 and 2019.

466.19 Sec. 9. Minnesota Statutes 2014, section 256.01, is amended by adding a subdivision  
 466.20 to read:

466.21 Subd. 40. **Nonfederal share transfers.** The nonfederal share of activities for  
 466.22 which federal administrative reimbursement is appropriated to the commissioner may  
 466.23 be transferred to the special revenue fund.

466.24 Sec. 10. Laws 2013, chapter 108, article 14, section 12, as amended by Laws 2014,  
 466.25 chapter 312, article 30, section 11, is amended to read:

466.26 **Sec. 12. APPROPRIATION ADJUSTMENTS.**

466.27 (a) The general fund appropriation in section 2, subdivision 5, paragraph (g),  
 466.28 includes up to \$53,391,000 in fiscal year 2014; \$216,637,000 in fiscal year 2015;  
 466.29 \$261,660,000 in fiscal year 2016; and \$279,984,000 in fiscal year 2017, for medical  
 466.30 assistance eligibility and administration changes related to:

466.31 (1) eligibility for children age two to 18 with income up to 275 percent of the federal  
 466.32 poverty guidelines;

467.1 (2) eligibility for pregnant women with income up to 275 percent of the federal  
 467.2 poverty guidelines;

467.3 (3) Affordable Care Act enrollment and renewal processes, including elimination  
 467.4 of six-month renewals, ex parte eligibility reviews, preprinted renewal forms, changes

467.5 in verification requirements, and other changes in the eligibility determination and  
467.6 enrollment and renewal process;

467.7 (4) automatic eligibility for children who turn 18 in foster care until they reach age 26;

467.8 (5) eligibility related to spousal impoverishment provisions for waiver recipients; and

467.9 (6) presumptive eligibility determinations by hospitals.

467.10 (b) the commissioner of human services shall determine the difference between the  
467.11 actual or estimated costs to the medical assistance program attributable to the program  
467.12 changes in paragraph (a), clauses (1) to (6), and the costs of paragraph (a), clauses (1)  
467.13 to (6), that were estimated during the 2013 legislative session based on data from the  
467.14 2013 February forecast.

467.15 (c) For each fiscal year from 2014 to ~~2017~~ 2019, the commissioner of human services  
467.16 shall certify the actual or estimated cost differences to the medical assistance program  
467.17 determined under paragraph (b), and report the difference in costs to the commissioner of  
467.18 management and budget at least four weeks prior to a forecast under Minnesota Statutes,  
467.19 section 16A.103. For fiscal years 2014 to ~~2017~~ 2019, forecasts under Minnesota Statutes,  
467.20 section 16A.103, prepared by the commissioner of management and budget shall include  
467.21 actual or estimated adjustments to the health care access fund appropriation in section 2,  
467.22 subdivision 5, paragraph (g), according to paragraph (d).

467.23 (d) For each fiscal year from 2014 to ~~2017~~ 2019, the commissioner of management  
467.24 and budget must adjust the health care access fund appropriation by the cumulative  
467.25 difference in costs reported by the commissioner of human services under paragraph  
467.26 (b). If, for any fiscal year, the amount of the cumulative difference in costs determined  
467.27 under paragraph (b) is positive, no adjustment shall be made to the health care access  
467.28 fund appropriation.

467.29 (e) This section expires on January 1, ~~2018~~ 2020.

467.30 Sec. 11. **TRANSFERS.**

467.31 Subdivision 1. **Grants.** The commissioner of human services, with the approval of  
467.32 the commissioner of management and budget, may transfer unencumbered appropriation  
467.33 balances for the biennium ending June 30, 2017, within fiscal years among the MFIP,  
467.34 general assistance, general assistance medical care under Minnesota Statutes 2009  
467.35 Supplement, section 256D.03, subdivision 3, medical assistance, MinnesotaCare, MFIP  
468.1 child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental  
468.2 aid, and group residential housing programs, the entitlement portion of Northstar Care  
468.3 for Children under Minnesota Statutes, chapter 256N, and the entitlement portion of  
468.4 the chemical dependency consolidated treatment fund, and between fiscal years of the

468.5 biennium. The commissioner shall inform the chairs and ranking minority members of  
 468.6 the senate Health and Human Services Finance Division and the house of representatives  
 468.7 Health and Human Services Finance Committee quarterly about transfers made under  
 468.8 this subdivision.

468.9 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative  
 468.10 money may be transferred within the Departments of Health and Human Services as the  
 468.11 commissioners consider necessary, with the advance approval of the commissioner of  
 468.12 management and budget. The commissioner shall inform the chairs and ranking minority  
 468.13 members of the senate Health and Human Services Finance Division and the house of  
 468.14 representatives Health and Human Services Finance Committee quarterly about transfers  
 468.15 made under this subdivision.

468.16 Sec. 12. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

468.17 The commissioners of health and human services shall not use indirect cost  
 468.18 allocations to pay for the operational costs of any program for which they are responsible.

468.19 Sec. 13. **EXPIRATION OF UNCODIFIED LANGUAGE.**

468.20 All uncodified language contained in this article expires on June 30, 2017, unless a  
 468.21 different expiration date is explicit.

468.22 Sec. 14. **EFFECTIVE DATE.**

468.23 This article is effective July 1, 2015, unless a different effective date is specified.

## 468.24 **ARTICLE 13**

### 468.25 **HUMAN SERVICES FORECAST ADJUSTMENTS**

468.26 Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

468.27 The dollar amounts shown are added to or, if shown in parentheses, are subtracted  
 468.28 from the appropriations in Laws 2013, chapter 108, article 14, as amended by Laws 2014,  
 468.29 chapter 312, article 30, from the general fund, or any other fund named, to the Department  
 468.30 of Human Services for the purposes specified in this article, to be available for the fiscal  
 469.1 years indicated for each purpose. The figure "2015" used in this article means that the  
 469.2 appropriations listed are available for the fiscal year ending June 30, 2015.

469.3  
 469.4  
 469.5  
 469.6

**APPROPRIATIONS**  
**Available for the Year**  
**Ending June 30**  
**2016**                      **2017**



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Article locations in S1458-2

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ARTICLE 4	DIRECT CARE AND TREATMENT .....	Page.Ln 163.1
ARTICLE 5	SIMPLIFICATION OF PUBLIC ASSISTANCE PROGRAMS .....	Page.Ln 166.20
ARTICLE 6	CONTINUING CARE .....	Page.Ln 185.19
ARTICLE 7	HEALTH DEPARTMENT .....	Page.Ln 219.11
ARTICLE 8	HEALTH CARE DELIVERY .....	Page.Ln 283.8
ARTICLE 9	HEALTH LICENSING BOARDS .....	Page.Ln 320.29
ARTICLE 10	HEALTH CARE .....	Page.Ln 331.1
ARTICLE 11	MNSURE .....	Page.Ln 407.5
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ARTICLE 13	HUMAN SERVICES FORECAST ADJUSTMENTS .....	Page.Ln 468.24

**62V.04 GOVERNANCE.**

Subdivision 1. **Board.** MNsure is governed by a board of directors with seven members.

Subd. 2. **Appointment.** (a) Board membership of MNsure consists of the following:

(1) three members appointed by the governor with the advice and consent of both the senate and the house of representatives acting separately in accordance with paragraph (d), with one member representing the interests of individual consumers eligible for individual market coverage, one member representing individual consumers eligible for public health care program coverage, and one member representing small employers. Members are appointed to serve four-year terms following the initial staggered-term lot determination;

(2) three members appointed by the governor with the advice and consent of both the senate and the house of representatives acting separately in accordance with paragraph (d) who have demonstrated expertise, leadership, and innovation in the following areas: one member representing the areas of health administration, health care finance, health plan purchasing, and health care delivery systems; one member representing the areas of public health, health disparities, public health care programs, and the uninsured; and one member representing health policy issues related to the small group and individual markets. Members are appointed to serve four-year terms following the initial staggered-term lot determination; and

(3) the commissioner of human services or a designee.

(b) Section 15.0597 shall apply to all appointments, except for the commissioner.

(c) The governor shall make appointments to the board that are consistent with federal law and regulations regarding its composition and structure. All board members appointed by the governor must be legal residents of Minnesota.

(d) Upon appointment by the governor, a board member shall exercise duties of office immediately. If both the house of representatives and the senate vote not to confirm an appointment, the appointment terminates on the day following the vote not to confirm in the second body to vote.

(e) Initial appointments shall be made by April 30, 2013.

(f) One of the six members appointed under paragraph (a), clause (1) or (2), must have experience in representing the needs of vulnerable populations and persons with disabilities.

(g) Membership on the board must include representation from outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2.

Subd. 3. **Terms.** (a) Board members may serve no more than two consecutive terms, except for the commissioner or the commissioner's designee, who shall serve until replaced by the governor.

(b) A board member may resign at any time by giving written notice to the board.

(c) The appointed members under subdivision 2, paragraph (a), clauses (1) and (2), shall have an initial term of two, three, or four years, determined by lot by the secretary of state.

Subd. 4. **Conflicts of interest.** (a) Within one year prior to or at any time during their appointed term, board members appointed under subdivision 2, paragraph (a), clauses (1) and (2), shall not be employed by, be a member of the board of directors of, or otherwise be a representative of a health carrier, institutional health care provider or other entity providing health care, navigator, insurance producer, or other entity in the business of selling items or services of significant value to or through MNsure. For purposes of this paragraph, "health care provider or entity" does not include an academic institution.

(b) Board members must recuse themselves from discussion of and voting on an official matter if the board member has a conflict of interest. A conflict of interest means an association including a financial or personal association that has the potential to bias or have the appearance of biasing a board member's decisions in matters related to MNsure or the conduct of activities under this chapter.

(c) No board member shall have a spouse who is an executive of a health carrier.

(d) No member of the board may currently serve as a lobbyist, as defined under section 10A.01, subdivision 21.

Subd. 5. **Acting chair; first meeting; supervision.** (a) The governor shall designate as acting chair one of the appointees described in subdivision 2.

(b) The board shall hold its first meeting within 60 days of enactment.

(c) The board shall elect a chair to replace the acting chair at the first meeting.

Subd. 6. **Chair.** The board shall have a chair, elected by a majority of members. The chair shall serve for one year.

Subd. 7. **Officers.** The members of the board shall elect officers by a majority of members. The officers shall serve for one year.

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Subd. 8. **Vacancies.** If a vacancy occurs, the governor shall appoint a new member within 90 days, and the newly appointed member shall be subject to the same confirmation process described in subdivision 2.

Subd. 9. **Removal.** (a) A board member may be removed by the appointing authority and a majority vote of the board following notice and hearing before the board. For purposes of this subdivision, the appointing authority or a designee of the appointing authority shall be a voting member of the board for purposes of constituting a quorum.

(b) A conflict of interest as defined in subdivision 4, shall be cause for removal from the board.

Subd. 10. **Meetings.** The board shall meet at least quarterly.

Subd. 11. **Quorum.** A majority of the members of the board constitutes a quorum, and the affirmative vote of a majority of members of the board is necessary and sufficient for action taken by the board.

Subd. 12. **Compensation.** (a) The board members shall be paid a salary not to exceed the salary limits established under section 15A.0815, subdivision 4. The salary for board members shall be set in accordance with this subdivision and section 15A.0815, subdivision 5. This paragraph expires December 31, 2015.

(b) Beginning January 1, 2016, the board members may be compensated in accordance with section 15.0575.

Subd. 13. **Advisory committees.** (a) The board shall establish and maintain advisory committees to provide insurance producers, health care providers, the health care industry, consumers, and other stakeholders with the opportunity to advise the board regarding the operation of MNsure as required under section 1311(d)(6) of the Affordable Care Act, Public Law 111-148. The board shall regularly consult with the advisory committees. The advisory committees established under this paragraph shall not expire.

(b) The board may establish additional advisory committees, as necessary, to gather and provide information to the board in order to facilitate the operation of MNsure. The advisory committees established under this paragraph shall not expire, except by action of the board.

(c) Section 15.0597 shall not apply to any advisory committee established by the board under this subdivision.

(d) The board may provide compensation and expense reimbursement under section 15.059, subdivision 3, to members of the advisory committees.

### **62V.09 EXPIRATION AND SUNSET EXCLUSION.**

Notwithstanding section 15.059, the board and its advisory committees shall not expire, except as specified in section 62V.04, subdivision 13. The board and its advisory committees are not subject to review or sunseting under chapter 3D.

### **62V.11 LEGISLATIVE OVERSIGHT COMMITTEE.**

Subdivision 1. **Legislative oversight.** (a) The Legislative Oversight Committee is established to provide oversight to the implementation of this chapter and the operation of MNsure.

(b) The committee shall review the operations of MNsure at least annually and shall recommend necessary changes in policy, implementation, and statutes to the board and to the legislature.

(c) MNsure shall present to the committee the annual report required in section 62V.08, the appeals process under section 62V.05, subdivision 6, and the actions taken regarding the treatment of multiemployer plans.

Subd. 2. **Membership; meetings; compensation.** (a) The Legislative Oversight Committee shall consist of five members of the senate, three members appointed by the majority leader of the senate, and two members appointed by the minority leader of the senate; and five members of the house of representatives, three members appointed by the speaker of the house, and two members appointed by the minority leader of the house of representatives.

(b) Appointed legislative members serve at the pleasure of the appointing authority and shall continue to serve until their successors are appointed.

(c) The first meeting of the committee shall be convened by the chair of the Legislative Coordinating Commission. Members shall elect a chair at the first meeting. The chair must convene at least one meeting annually, and may convene other meetings as deemed necessary.

Subd. 3. **Review of proposed rules.** (a) Prior to the implementation of rules proposed under section 62V.05, subdivision 8, paragraph (b), the board shall submit the proposed rules to the committee at the same time the proposed rules are published in the State Register.



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(b) When the legislature is in session, the rule may be adopted, but, if within ten days of receipt of the proposed rule a majority of the committee members appointed by the senate and a majority of the committee members appointed by the house of representatives request further review of the proposed rule, the rule shall not be effective until the request has been satisfied and withdrawn, the rule is approved in law, or the regular session of the legislature is adjourned for the year.

(c) If the legislature is not in session, the rule may be adopted, but, if within ten days of receipt of the proposed rule a majority of the committee members appointed by the senate and a majority of the committee members appointed by the house of representatives request further review of the proposed rule, the rule shall not be effective until the request has been satisfied and withdrawn, or February 1, whichever occurs first.

Subd. 4. **Review of costs.** The board shall submit for review the annual budget of MNsure for the next fiscal year by March 15 of each year, beginning March 15, 2014.

#### **144E.52 FUNDING FOR EMERGENCY MEDICAL SERVICES REGIONS.**

The Emergency Medical Services Regulatory Board shall distribute funds appropriated from the general fund equally among the emergency medical service regions. Each regional board may use this money to reimburse eligible emergency medical services personnel for continuing education costs related to emergency care that are personally incurred and are not reimbursed from other sources. Eligible emergency medical services personnel include, but are not limited to, dispatchers, emergency room physicians, emergency room nurses, emergency medical responders, emergency medical technicians, and paramedics.

#### **148E.060 TEMPORARY LICENSES.**

Subd. 12. **Ineligibility.** An applicant who is currently practicing social work in Minnesota in a setting that is not exempt under section 148E.065 at the time of application is ineligible for a temporary license.

#### **256.969 PAYMENT RATES.**

Subd. 23. **Hospital payment adjustment after June 30, 1993.** (a) For admissions occurring after June 30, 1993, the commissioner shall adjust the medical assistance payment paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment under clause (1) for that hospital by 1.1.

(b) Any payment under this subdivision must be reduced by the amount of any payment received under subdivision 9, paragraph (b), clause (1) or (2). For purposes of this subdivision, medical assistance does not include general assistance medical care.

(c) The commissioner shall adjust rates paid to a health maintenance organization under contract with the commissioner to reflect rate increases provided in this section. The adjustment must be made on a nondiscounted hospital-specific basis.

Subd. 30. **Payment rates for births.** (a) For admissions occurring on or after November 1, 2014, the total operating and property payment rate, excluding disproportionate population adjustment, for the following diagnosis-related groups, as they fall within the APR-DRG categories: (1) 5601, 5602, 5603, 5604 vaginal delivery; and (2) 5401, 5402, 5403, 5404 cesarean section, shall be no greater than \$3,528.

(b) The rates described in this subdivision do not include newborn care.

(c) Payments to managed care and county-based purchasing plans under section 256B.69, 256B.692, or 256L.12 shall be reduced for services provided on or after October 1, 2009, to reflect the adjustments in paragraph (a).

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(d) Prior authorization shall not be required before reimbursement is paid for a cesarean section delivery.

**256B.69 PREPAID HEALTH PLANS.**

Subd. 32. **Initiatives to reduce incidence of low birth weight.** The commissioner shall require managed care and county-based purchasing plans, as a condition of contract, to implement strategies to reduce the incidence of low birth weight in geographic areas identified by the commissioner as having a higher than average incidence of low birth weight. The strategies must coordinate health care with social services and the local public health system. Each plan shall develop and report to the commissioner outcome measures related to reducing the incidence of low birth weight. The commissioner shall consider the outcomes reported when considering plan participation in the competitive bidding program established under subdivision 33.

**256D.0513 BUDGETING LUMP SUMS.**

Effective January 1, 1998, nonrecurring lump-sum income received by a recipient of general assistance must be budgeted in the normal retrospective cycle.

**256D.06 AMOUNT OF ASSISTANCE.**

Subd. 8. **Recovery of ATM errors.** For recipients receiving benefits via electronic benefit transfer, if the recipient is overpaid as a result of an automated teller machine (ATM) dispensing funds in error to the recipient, the agency may recover the ATM error by immediately withdrawing funds from the recipient's electronic benefit transfer account, up to the amount of the error.

**256D.09 PAYMENT; ASSESSMENT; OVERPAYMENT.**

Subd. 6. **Recovery of overpayments.** (a) If an amount of general assistance or family general assistance is paid to a recipient in excess of the payment due, it shall be recoverable by the county agency. The agency shall give written notice to the recipient of its intention to recover the overpayment.

(b) Except as provided for interim assistance in section 256D.06, subdivision 5, when an overpayment occurs, the county agency shall recover the overpayment from a current recipient by reducing the amount of aid payable to the assistance unit of which the recipient is a member, for one or more monthly assistance payments, until the overpayment is repaid. All county agencies in the state shall reduce the assistance payment by three percent of the assistance unit's standard of need in nonfraud cases and ten percent where fraud has occurred, or the amount of the monthly payment, whichever is less, for all overpayments.

(c) In cases when there is both an overpayment and underpayment, the county agency shall offset one against the other in correcting the payment.

(d) Overpayments may also be voluntarily repaid, in part or in full, by the individual, in addition to the aid reductions provided in this subdivision, to include further voluntary reductions in the grant level agreed to in writing by the individual, until the total amount of the overpayment is repaid.

(e) The county agency shall make reasonable efforts to recover overpayments to persons no longer on assistance under standards adopted in rule by the commissioner of human services. The county agency need not attempt to recover overpayments of less than \$35 paid to an individual no longer on assistance if the individual does not receive assistance again within three years, unless the individual has been convicted of violating section 256.98.

(f) Establishment of an overpayment is limited to 12 months prior to the month of discovery due to agency error and six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

**256D.49 PAYMENT CORRECTION.**

Subdivision 1. **When.** When the county agency finds that the recipient has received less than or more than the correct payment of Minnesota supplemental aid benefits, the county agency shall issue a corrective payment or initiate recovery under subdivision 3, as appropriate.

Subd. 2. **Underpayment of monthly grants.** When the county agency determines that an underpayment of the recipient's monthly payment has occurred, it shall, during that same month, issue a corrective payment. Corrective payments must be excluded when determining the applicant's or recipient's income and resources for the month of payment.

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Subd. 3. **Overpayment of monthly grants and recovery of ATM errors.** (a) When the county agency determines that an overpayment of the recipient's monthly payment of Minnesota supplemental aid has occurred, it shall issue a notice of overpayment to the recipient. If the person is no longer receiving Minnesota supplemental aid, the county agency may request voluntary repayment or pursue civil recovery. If the person is receiving Minnesota supplemental aid, the county agency shall recover the overpayment by withholding an amount equal to three percent of the standard of assistance for the recipient or the total amount of the monthly grant, whichever is less.

(b) Establishment of an overpayment is limited to 12 months from the date of discovery due to agency error. Establishment of an overpayment is limited to six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

(c) For recipients receiving benefits via electronic benefit transfer, if the overpayment is a result of an automated teller machine (ATM) dispensing funds in error to the recipient, the agency may recover the ATM error by immediately withdrawing funds from the recipient's electronic benefit transfer account, up to the amount of the error.

(d) Residents of licensed residential facilities shall not have overpayments recovered from their personal needs allowance.

### **256J.38 CORRECTION OF OVERPAYMENTS AND UNDERPAYMENTS.**

Subdivision 1. **Scope of overpayment.** (a) When a participant or former participant receives an overpayment due to agency, client, or ATM error, or due to assistance received while an appeal is pending and the participant or former participant is determined ineligible for assistance or for less assistance than was received, the county agency must recoup or recover the overpayment using the following methods:

- (1) reconstruct each affected budget month and corresponding payment month;
- (2) use the policies and procedures that were in effect for the payment month; and
- (3) do not allow employment disregards in section 256J.21, subdivision 3 or 4, in the calculation of the overpayment when the unit has not reported within two calendar months following the end of the month in which the income was received.

(b) Establishment of an overpayment is limited to 12 months prior to the month of discovery due to agency error. Establishment of an overpayment is limited to six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

Subd. 2. **Notice of overpayment.** When a county agency discovers that a participant or former participant has received an overpayment for one or more months, the county agency must notify the participant or former participant of the overpayment in writing. A notice of overpayment must specify the reason for the overpayment, the authority for citing the overpayment, the time period in which the overpayment occurred, the amount of the overpayment, and the participant's or former participant's right to appeal. No limit applies to the period in which the county agency is required to recoup or recover an overpayment according to subdivisions 3 and 4.

Subd. 3. **Recovering overpayments.** A county agency must initiate efforts to recover overpayments paid to a former participant or caregiver. Caregivers, both parental and nonparental, and minor caregivers of an assistance unit at the time an overpayment occurs, whether receiving assistance or not, are jointly and individually liable for repayment of the overpayment. The county agency must request repayment from the former participants and caregivers. When an agreement for repayment is not completed within six months of the date of discovery or when there is a default on an agreement for repayment after six months, the county agency must initiate recovery consistent with chapter 270A, or section 541.05. When a person has been convicted of fraud under section 256.98, recovery must be sought regardless of the amount of overpayment. When an overpayment is less than \$35, and is not the result of a fraud conviction under section 256.98, the county agency must not seek recovery under this subdivision. The county agency must retain information about all overpayments regardless of the amount. When an adult, adult caregiver, or minor caregiver reapplies for assistance, the overpayment must be recouped under subdivision 4.

Subd. 4. **Recouping overpayments from participants.** A participant may voluntarily repay, in part or in full, an overpayment even if assistance is reduced under this subdivision, until the total amount of the overpayment is repaid. When an overpayment occurs due to fraud, the county agency must recover from the overpaid assistance unit, including child only cases, ten percent of the applicable standard or the amount of the monthly assistance payment, whichever is less. When a nonfraud overpayment occurs, the county agency must recover from the overpaid assistance unit, including child only cases, three percent of the MFIP standard of need or the amount of the monthly assistance payment, whichever is less.

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Subd. 5. **Recovering automatic teller machine errors.** For recipients receiving benefits via electronic benefit transfer, if the overpayment is a result of an ATM dispensing funds in error to the recipient, the agency may recover the ATM error by immediately withdrawing funds from the recipient's electronic benefit transfer account, up to the amount of the error.

Subd. 6. **Scope of underpayments.** A county agency must issue a corrective payment for underpayments made to a participant or to a person who would be a participant if an agency or client error causing the underpayment had not occurred. Corrective payments are limited to 12 months prior to the month of discovery. The county agency must issue the corrective payment according to subdivision 8.

Subd. 7. **Identifying the underpayment.** An underpayment may be identified by a county agency, by a participant, by a former participant, or by a person who would be a participant except for agency or client error.

Subd. 8. **Issuing corrective payments.** A county agency must correct an underpayment within seven calendar days after the underpayment has been identified, by adding the corrective payment amount to the monthly assistance payment of the participant or by issuing a separate payment to a participant or former participant, or by reducing an existing overpayment balance. When an underpayment occurs in a payment month and is not identified until the next payment month or later, the county agency must first subtract the underpayment from any overpayment balance before issuing the corrective payment. The county agency must not apply an underpayment in a current payment month against an overpayment balance. When an underpayment in the current payment month is identified, the corrective payment must be issued within seven calendar days after the underpayment is identified.

Subd. 9. **Appeals.** A participant may appeal an underpayment, an overpayment, and a reduction in an assistance payment made to recoup the overpayment under subdivision 4. The participant's appeal of each issue must be timely under section 256.045. When an appeal based on the notice issued under subdivision 2 is not timely, the fact or the amount of that overpayment must not be considered as a part of a later appeal, including an appeal of a reduction in an assistance payment to recoup that overpayment.

#### **256L.02 PROGRAM ADMINISTRATION.**

Subd. 3. **Financial management.** (a) The commissioner shall manage spending for the MinnesotaCare program in a manner that maintains a minimum reserve. As part of each state revenue and expenditure forecast, the commissioner must make an assessment of the expected expenditures for the covered services for the remainder of the current biennium and for the following biennium. The estimated expenditure, including the reserve, shall be compared to an estimate of the revenues that will be available in the health care access fund. Based on this comparison, and after consulting with the chairs of the house of representatives Ways and Means Committee and the senate Finance Committee, the commissioner shall, as necessary, make the adjustments specified in paragraph (b) to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium. The commissioner shall not hire additional staff using appropriations from the health care access fund until the commissioner of management and budget makes a determination that the adjustments implemented under paragraph (b) are sufficient to allow MinnesotaCare expenditures to remain within the limits of available revenues for the remainder of the current biennium and for the following biennium.

(b) The adjustments the commissioner shall use must be implemented in this order: first, stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the MinnesotaCare program; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the MinnesotaCare program. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner shall further limit enrollment or decrease premium subsidies.

#### **256L.05 APPLICATION PROCEDURES.**

Subd. 1b. **MinnesotaCare enrollment by county agencies.** Beginning September 1, 2006, county agencies shall enroll single adults and households with no children formerly enrolled in general assistance medical care in MinnesotaCare according to Minnesota Statutes

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2009 Supplement, section 256D.03, subdivision 3. County agencies shall perform all duties necessary to administer the MinnesotaCare program ongoing for these enrollees, including the redetermination of MinnesotaCare eligibility at renewal.

Subd. 1c. **Open enrollment and streamlined application and enrollment process.**

Subd. 3c. **Retroactive coverage.** Notwithstanding subdivision 3, the effective date of coverage shall be the first day of the month following termination from medical assistance for families and individuals who are eligible for MinnesotaCare and who submitted a written request for retroactive MinnesotaCare coverage with a completed application within 30 days of the mailing of notification of termination from medical assistance. The applicant must provide all required verifications within 30 days of the written request for verification. For retroactive coverage, premiums must be paid in full for any retroactive month, current month, and next month within 30 days of the premium billing. This subdivision does not apply, and shall not be implemented by the commissioner, once eligibility determination for MinnesotaCare is conducted by the MNsure eligibility determination system.

Subd. 5. **Availability of private insurance.** The commissioner, in consultation with the commissioners of health and commerce, shall provide information regarding the availability of private health insurance coverage and the possibility of disenrollment under section 256L.07, subdivision 1, to all: (1) families enrolled in the MinnesotaCare program whose gross family income is equal to or more than 225 percent of the federal poverty guidelines; and (2) single adults and households without children enrolled in the MinnesotaCare program whose gross family income is equal to or more than 165 percent of the federal poverty guidelines. This information must be provided upon initial enrollment and annually thereafter. The commissioner shall also include information regarding the availability of private health insurance coverage in the notice of ineligibility provided to persons subject to disenrollment under section 256L.07, subdivision 1.

#### **256L.11 PROVIDER PAYMENT.**

Subd. 7. **Critical access dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after January 1, 2007, through August 31, 2011, 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 50 percent above the payment rate that would otherwise be paid to the provider. Effective for dental services provided on or after September 1, 2011, the commissioner shall increase the payment rate by 30 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.

#### **257.0768 COMMUNITY-SPECIFIC BOARDS.**

Subdivision 1. **Membership.** Four community-specific boards are created. Each board consists of five members. The chair of each of the following groups shall appoint the board for the community represented by the group: the Indian Affairs Council; the Council on Affairs of Chicano/Latino people; the Council on Black Minnesotans; and the Council on Asian-Pacific Minnesotans. In making appointments, the chair must consult with other members of the council.

Subd. 2. **Compensation; chair.** Members do not receive compensation but are entitled to receive reimbursement for reasonable and necessary expenses incurred.

Subd. 3. **Meetings.** Each board shall meet regularly at the request of the appointing chair or the ombudsperson.

Subd. 4. **Duties.** Each board shall appoint the ombudsperson for its community. Each board shall advise and assist the ombudsperson for its community in selecting matters for attention; developing policies, plans, and programs to carry out the ombudspersons' functions and powers; establishing protocols for working with the communities of color; developing procedures for the ombudspersons' use of the subpoena power to compel testimony and evidence from nonagency individuals; and making reports and recommendations for changes designed to improve standards of competence, efficiency, justice, and protection of rights.

Subd. 5. **Terms, compensation, removal, and expiration.** The membership terms, compensation, and removal of members of each board and the filling of membership vacancies are governed by section 15.0575.

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Subd. 6. **Joint meetings.** The members of the four community-specific boards shall meet jointly at least four times each year to advise the ombudspersons on overall policies, plans, protocols, and programs for the office.

**290.0671 MINNESOTA WORKING FAMILY CREDIT.**

Subd. 6a. **TANF appropriation for working family credit expansion.** (a) On an annual basis the commissioner of revenue, with the assistance of the commissioner of human services, shall calculate the value of the refundable portion of the Minnesota Working Family Credit provided under this section that qualifies for payment with funds from the federal Temporary Assistance for Needy Families (TANF) block grant. Of this total amount, the commissioner of revenue shall estimate the portion entailed by the expansion of the credit rates for individuals with qualifying children over the rates provided in Laws 1999, chapter 243, article 2, section 12.

(b) An amount sufficient to pay the refunds entailed by the expansion of the credit rates for individuals with qualifying children over the rates provided in Laws 1999, chapter 243, article 2, section 12, as estimated in paragraph (a), is appropriated to the commissioner of human services from the federal Temporary Assistance for Needy Families (TANF) block grant funds, for transfer to the commissioner of revenue for deposit in the general fund.

**3400.0170 INCOME ELIGIBILITY FOR CHILD CARE ASSISTANCE.**

Subp. 5. **Earned income of wage and salary employees.** Earned income means earned income from employment before mandatory and voluntary payroll deductions. Earned income includes, but is not limited to, salaries, wages, tips, gratuities, commissions, incentive payments from work or training programs, payments made by an employer for regularly accrued vacation or sick leave, payment for jury duty, and profits from other activity earned by an individual's effort or labor. Earned income includes uniform, mileage, and meal allowances if federal income tax is deducted from the allowance. Earned income includes flexible work benefits received from an employer if the employee has the option of receiving the benefit or benefits in cash. Earned income received by persons employed on a contractual basis must be prorated over the period covered by the contract even when payments are received over a lesser period of time. When housing is provided as part of the total work compensation, the fair market value of such housing shall be considered as if it were paid in cash.

**3400.0170 INCOME ELIGIBILITY FOR CHILD CARE ASSISTANCE.**

Subp. 6. **Excluded income.** The administering agency shall exclude items A to H from annual income:

- A. scholarships, work-study income, and grants that cover costs or reimburse for tuition, fees, books, and educational supplies;
- B. student loans for tuition, fees, books, supplies, and living expenses;
- C. state and federal earned income tax credits, in-kind noncash public assistance income such as food stamps or food support, energy assistance, foster care assistance, child care assistance, medical assistance, and housing subsidies;
- D. earned income of full-time or part-time students up to the age of 19 who have not earned a high school diploma or GED high school equivalency diploma, including earnings from summer employment;
- E. grant awards under the family subsidy program;
- F. nonrecurring lump sum income that is earmarked and used for the purpose for which it is paid;
- G. supplemental security income; and
- H. income assigned to the public authority under Minnesota Statutes, section 256.741.

**3400.0170 INCOME ELIGIBILITY FOR CHILD CARE ASSISTANCE.**

Subp. 12. **Determination of unearned income.** Unearned income includes, but is not limited to, the cash portion of MFIP or DWP; adoption assistance; relative custody assistance received under Minnesota Statutes, section 257.85; interest; dividends; unemployment compensation; disability insurance payments; veteran benefits; pension payments; child support and spousal support received or anticipated to be received by a family including child support and maintenance distributed to the family under Minnesota Statutes, section 256.741, subdivision 15; insurance payments or settlements; retirement; survivor's and disability insurance (RSDI) payment; and severance payments. Expenditures necessary to secure payment of unearned income are deducted from unearned income. Payments for illness or disability, except for those payments described as earned income in subpart 5, are considered unearned income whether the premium payments are made wholly or in part by an employer or by a recipient.

**3400.0170 INCOME ELIGIBILITY FOR CHILD CARE ASSISTANCE.**

Subp. 13. **Treatment of lump-sum payments.** Lump-sum payments received by a family must be considered earned income under subparts 7 to 11 or unearned income according to subpart 12. Nonrecurring lump sums that are earmarked and used for the purpose for which they are paid are not to be included in the determination of income. All other lump sums are to be annualized over 12 months. The sale of property including, but not limited to, a residence is not considered income up to the amount of the original purchase price plus improvements.

**8840.5900 DRIVER QUALIFICATIONS.**

Subp. 12. **Criminal record.** A driver must not have a criminal record for which the person was convicted of or pled guilty to, either crimes against persons or crimes reasonably related to providing special transportation services.

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A. For purposes of this subpart, "criminal record" means the conviction records of the Minnesota Bureau of Criminal Apprehension or other states' criminal history repository in which the last date of discharge from the criminal justice system is less than 15 years.

B. Conviction has the meaning given it in Minnesota Statutes, section 171.01, subdivision 29.

C. Criminal record and driving record includes a conviction, suspension, cancellation, or revocation for a crime in another jurisdiction that would be a violation under this part.

D. The following offenses are considered crimes against persons or reasonably related to providing special transportation services, or both:

- (1) Minnesota Statutes, section 609.17, attempts;
- (2) Minnesota Statutes, section 609.175, conspiracy;
- (3) Minnesota Statutes, section 609.185, murder in the first degree;
- (4) Minnesota Statutes, section 609.19, murder in the second degree;
- (5) Minnesota Statutes, section 609.195, murder in the third degree;
- (6) Minnesota Statutes, section 609.20, manslaughter in the first degree;
- (7) Minnesota Statutes, section 609.205, manslaughter in the second degree;
- (8) Minnesota Statutes, section 609.2112, 609.2113, or 609.2114, or Minnesota Statutes 2012, section 609.21, criminal vehicular homicide and injury;
- (9) Minnesota Statutes, section 609.215, suicide;
- (10) Minnesota Statutes, section 609.221, assault in the first degree;
- (11) Minnesota Statutes, section 609.222, assault in the second degree;
- (12) Minnesota Statutes, section 609.223, assault in the third degree;
- (13) Minnesota Statutes, section 609.2231, assault in the fourth degree;
- (14) Minnesota Statutes, section 609.224, assault in the fifth degree;
- (15) Minnesota Statutes, section 609.228, great bodily harm caused by distribution of drugs;
- (16) Minnesota Statutes, section 609.23, mistreatment of persons confined;
- (17) Minnesota Statutes, section 609.231, mistreatment of residents or patients;
- (18) Minnesota Statutes, section 609.235, use of drugs to injure or facilitate crime;
- (19) Minnesota Statutes, section 609.24, simple robbery;
- (20) Minnesota Statutes, section 609.245, aggravated robbery;
- (21) Minnesota Statutes, section 609.25, kidnapping;
- (22) Minnesota Statutes, section 609.255, false imprisonment;
- (23) Minnesota Statutes, section 609.265, abduction;
- (24) Minnesota Statutes, section 609.2661, murder of an unborn child in the first degree;
- (25) Minnesota Statutes, section 609.2662, murder of an unborn child in the second degree;
- (26) Minnesota Statutes, section 609.2663, murder of an unborn child in the third degree;
- (27) Minnesota Statutes, section 609.2664, manslaughter of an unborn child in the first degree;
- (28) Minnesota Statutes, section 609.2665, manslaughter of an unborn child in the second degree;
- (29) Minnesota Statutes, section 609.267, assault of an unborn child in the first degree;
- (30) Minnesota Statutes, section 609.2671, assault of an unborn child in the second degree;
- (31) Minnesota Statutes, section 609.2672, assault of an unborn child in the third degree;
- (32) Minnesota Statutes, section 609.268, injury or death of an unborn child in the commission of a crime;
- (33) Minnesota Statutes, section 609.322, solicitation, inducement, and promotion of prostitution;
- (34) Minnesota Statutes, section 609.323, receiving profit from prostitution;



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- (35) Minnesota Statutes, section 609.324, subdivisions 1 and 1a, other prohibited acts;
- (36) Minnesota Statutes, section 609.33, disorderly house;
- (37) Minnesota Statutes, section 609.342, criminal sexual conduct in the first degree;
- (38) Minnesota Statutes, section 609.343, criminal sexual conduct in the second degree;
- (39) Minnesota Statutes, section 609.344, criminal sexual conduct in the third degree;
- (40) Minnesota Statutes, section 609.345, criminal sexual conduct in the fourth degree;
- (41) Minnesota Statutes, section 609.3451, criminal sexual conduct in the fifth degree;
- (42) Minnesota Statutes, section 609.352, solicitation of children to engage in sexual conduct;
- (43) Minnesota Statutes, section 609.365, incest;
- (44) Minnesota Statutes, section 609.377, malicious punishment of a child;
- (45) Minnesota Statutes, section 609.378, neglect or endangerment of a child;
- (46) Minnesota Statutes, section 609.498, tampering with a witness;
- (47) Minnesota Statutes, section 609.52, felony theft;
- (48) Minnesota Statutes, section 609.561, arson in the first degree;
- (49) Minnesota Statutes, section 609.582, subdivisions 1 and 2, burglary;
- (50) Minnesota Statutes, section 609.713, terroristic threats;
- (51) Minnesota Statutes, section 609.749, nonfelony, harassment and stalking;
- (52) Minnesota Statutes, section 617.23, indecent exposure;
- (53) Minnesota Statutes, section 617.241, obscene materials and performances;
- (54) Minnesota Statutes, section 617.243, indecent literature, distribution;
- (55) Minnesota Statutes, section 617.246, use of minors in sexual performance;
- (56) Minnesota Statutes, section 617.247, possession of pictorial representations of minors;
- (57) Minnesota Statutes, section 617.293, harmful materials; dissemination and display to minors; and
- (58) felony convictions under Minnesota Statutes, chapter 152, prohibited drugs.

**8840.5900 DRIVER QUALIFICATIONS.**

Subp. 14. **Provider responsibility; driver's traffic and criminal record.** Before using or hiring a driver to provide special transportation service, a provider must obtain and review the driving and criminal records of a driver. In addition, a provider shall annually review the driving and criminal record of a driver it uses or employs.

A. The driving and criminal record review must include an examination of the records of the Department of Public Safety, Division of Driver and Vehicle Services, to determine if the driver meets the standards of subparts 9, 10, and 11. The review must also include an examination of the conviction records of the Minnesota Bureau of Criminal Apprehension to determine if the driver has a criminal record of convictions for crimes listed in subpart 12.

B. A provider satisfies the requirements of this subpart by obtaining a background check from the Minnesota Bureau of Criminal Apprehension. A private business or local law enforcement agency may be used for conducting the criminal background check if the review consists of an examination of the records of the Minnesota Bureau of Criminal Apprehension.

C. If a person has resided in Minnesota for less than ten years, the provider shall also conduct a search of the criminal history repository records in each state where the person has resided for the preceding ten years.

D. If a person has held a driver's license in a state other than Minnesota for the preceding three years, the provider shall review the driving record in each state where the person has held a driver's license for the preceding three-year period.