State of Minnesota

HOUSE OF REPRESENTATIVES

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NINETIETH SESSION

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Read First Time and Referred to the Committee on Ways and Means
04/05/2017 Adoption of Report: Placed on the General Register as Amended
Read for the Second Time

A bill for an act

relating to state government; establishing the health and human services budget; modifying provisions governing health care, continuing care, health department and public health, children and families, health occupations, chemical and mental health, and opiate abuse prevention; establishing prescribed pediatric extended care center license; modifying certain definitions; establishing federally facilitated marketplace; modifying sections related to telemedicine, nursing, psychology, dentistry, and medical practice; requiring legislative approval for certain federal waivers and approval; repealing MNsure; making technical changes; requiring reports; establishing and modifying fees; making forecast adjustments; appropriating money; amending Minnesota Statutes 2016, sections 3.972, by adding a subdivision; 62A.671, subdivision 6; 119B.011, by adding subdivisions; 119B.02, subdivision 5; 119B.03, subdivisions 4, 6; 119B.09, subdivision 9a; 119B.125, subdivisions 4, 6; 119B.13, subdivisions 1, 6; 119B.16, subdivisions 1, 1a, 1b, by adding subdivisions; 144.0722, subdivision 1; 144.0724, subdivisions 1, 2, 6, 9; 144.1501, subdivision 2; 144.1506; 144.551, subdivision 1; 144.562, subdivision 2; 144.99, subdivision 1; 144A.071, subdivisions 3, 4a, 4c, 4d; 144A.073, subdivision 3c; 144A.10, subdivision 4; 144A.15, subdivision 2; 144A.154; 144A.161, subdivision 10; 144A.1888; 144A.474, subdivision 11; 144A.4799, subdivision 3; 144A.611, subdivision 1; 144A.70, subdivision 6, by adding a subdivision; 144A.74; 145.4131, subdivision 1; 145.4716, subdivision 2; 148.171, subdivision 7b, by adding a subdivision; 148.211, subdivisions 1a, 1c, 2; 148.881; 148.89; 148.90, subdivisions 1, 2; 148.905, subdivision 1; 148.907, subdivisions 1, 2; 148.9105, subdivisions 1, 4, 5; 148.916, subdivisions 1, 1a; 148.925; 148.96, subdivision 3; 148B.53, subdivision 1; 150A.06, subdivisions 3, 8; 150A.10, subdivision 4; 151.01, subdivision 5, by adding subdivisions; 151.21; 152.11, by adding a subdivision; 245.462, subdivision 9; 245.4871, by adding a subdivision; 245.4876, subdivision 2; 245.4889, subdivision 1; 245.814, subdivisions 2, 3; 245A.02, subdivisions 2b, 5a, by adding subdivisions; 245A.03, subdivision 2; 245A.04, subdivision 4; 245A.06, subdivision 8, by adding a subdivision; 245A.191; 245D.03, subdivision 1; 245E.01, by adding a subdivision; 245E.02, subdivisions 1, 3, 4; 245E.03, subdivisions 2, 4; 245E.04; 245E.05, subdivision 1; 245E.06, subdivisions 1, 2, 3; 245E.07, subdivision 1; 252.27, subdivision 2a; 252.41, subdivision 3; 254A.03, subdivision 3; 254A.08, subdivision 2; 254B.01, by adding a subdivision; 254B.03, subdivision 2; 254B.05, subdivisions 1, 5; 254B.12, by adding a subdivision; 256.9657, subdivision 1; 256.9686, subdivision 8; 256.969, subdivisions 1, 2b, 3a, 4b, 8, 8c, 9, 12, by adding a subdivision; 256.98, subdivision 8; 256B.04, subdivision 12; 256B.0621, subdivision 10; 256B.0625, subdivisions 3b, 6a, 13, 13e, 17, 17b, 18h, 20, 30, 45a, 60a, 64, by adding subdivisions; 256B.0644;

256B.0653, subdivisions 2, 3, 4, 5, 6, by adding a subdivision; 256B.072; 256B.0755; 256B.0915, subdivision 3e; 256B.0924, by adding a subdivision; 256B.0943, subdivision 13; 256B.0945, subdivisions 2, 4; 256B.15, subdivisions 1, 1a, 2; 256B.196, subdivisions 2, 3, 4; 256B.35, subdivision 4; 256B.431, subdivision 30; 256B.434, subdivision 4; 256B.4913, subdivision 4a, by adding a subdivision; 256B.4914, subdivisions 2, 3, 5, 6, 7, 8, 9, 10; 256B.50, subdivisions 1, 1b; 256B.5012, by adding subdivisions; 256B.69, subdivision 5a, by adding a subdivision; 256B.75; 256B.763; 256B.766; 256C.23, subdivision 2, by adding subdivisions; 256C.233, subdivisions 1, 2; 256C.24, subdivisions 1, 2; 256C.261; 256I.04, subdivisions 1, 3; 256I.05, by adding subdivisions; 256I.06, subdivision 8; 256J.45, subdivision 2; 256L.15, subdivision 2; 256P.06, subdivision 2; 256R.02, subdivisions 4, 17, 18, 19, 22, 42, 52, by adding subdivisions; 256R.06, subdivision 5; 256R.07, subdivision 1, by adding a subdivision; 256R.13, subdivision 4; 256R.37; 256R.40, subdivisions 1, 5; 256R.41; 256R.47; 256R.49; 256R.53, subdivision 2; 260C.451, subdivision 6; 609.5315, subdivision 5c; 626.556, subdivisions 2, 3, 3c, 10d; Laws 2015, chapter 71, article 7, section 54; proposing coding for new law in Minnesota Statutes, chapters 119B; 144; 147; 148; 152; 181; 245A; 256; 256B; 256N; 256R; proposing coding for new law as Minnesota Statutes, chapter 144H; repealing Minnesota Statutes 2016, sections 62V.01; 62V.02; 62V.03; 62V.04; 62V.05; 62V.051; 62V.055; 62V.06; 62V.07; 62V.08; 62V.09; 62V.10; 62V.11; 119B.16, subdivision 2; 144.4961; 147.0375, subdivision 7; 148.211, subdivision 1b; 148.243, subdivision 15; 148.906; 148.907, subdivision 5; 148.908; 148.909, subdivision 7; 148.96, subdivisions 4, 5; 179A.50; 179A.51; 179A.52; 179A.53; 245E.03, subdivision 3; 245E.06, subdivisions 4, 5; 256B.4914, subdivision 16; 256B.7631; 256C.23, subdivision 3; 256C.233, subdivision 4; 256C.25, subdivisions 1, 2; Minnesota Rules, part 3400.0185, subpart 5.

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

ARTICLE 1

HEALTH CARE

Section 1. Minnesota Statutes 2016, section 3.972, is amended by adding a subdivision to read:

Subd. 2a. **Audits of Department of Human Services.** (a) To ensure continuous legislative oversight and accountability, the legislative auditor shall give high priority to auditing the programs, services, and benefits administered by the Department of Human Services. The audits shall determine whether the department offered programs and provided services and benefits only to eligible persons and organizations, and complied with applicable legal requirements.

(b) The legislative auditor shall, no less than three times each year, test a representative sample of persons enrolled in medical assistance and MinnesotaCare to determine whether they are eligible to receive benefits under those programs. The legislative auditor shall report the results to the commissioner of human services and recommend corrective actions, which the commissioner must implement within 20 business days. The legislative auditor shall monitor the commissioner's implementation of corrective actions and periodically report the results to the Legislative Audit Commission and the chairs and ranking minority members

of the legislative committees with jurisdiction over health and human services policy and finance. The legislative auditor's reports to the commission and the chairs and ranking minority members must include recommendations for any legislative actions needed to ensure that medical assistance and MinnesotaCare benefits are provided only to eligible persons.

Sec. 2. Minnesota Statutes 2016, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 124D.23 or 245.493; or

(4) mental health service providers.

(b) The following services are eligible for grants under this section:

(1) services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with severe emotional disturbances who are at risk of out-of-home placement;

(4) children's mental health crisis services;

(5) mental health services for people from cultural and ethnic minorities;

(6) children's mental health screening and follow-up diagnostic assessment and treatment;

(7) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(8) school-linked mental health services;

(9) building evidence-based mental health intervention capacity for children birth to age five;

(10) suicide prevention and counseling services that use text messaging statewide;

(11) mental health first aid training;

(12) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive Web site to share information and strategies to promote resilience and prevent trauma;

(13) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(14) early childhood mental health consultation;

(15) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis; ~~and~~

(16) psychiatric consultation for primary care practitioners~~.~~; and

(17) start-up funding to support providers in meeting program requirements and beginning operations when establishing a new children's mental health program.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under paragraph (b) must be designed to foster independent living in the community.

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

Sec. 3. Minnesota Statutes 2016, section 256.9686, subdivision 8, is amended to read:

Subd. 8. **Rate year.** "Rate year" means a calendar year from January 1 to December 31. Effective with the 2012 base year, rate year means a state fiscal year from July 1 to June 30.

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

Sec. 4. Minnesota Statutes 2016, section 256.969, subdivision 1, is amended to read:

Subdivision 1. **Hospital cost index.** (a) The hospital cost index shall be the change in the Centers for Medicare and Medicaid Services Inpatient Hospital Market Basket. The commissioner shall use the indices as forecasted for the midpoint of the prior rate year to the midpoint of the current rate year.

(b) Except as authorized under this section, for fiscal years beginning on or after July 1, 1993, the commissioner of human services shall not provide automatic annual inflation adjustments for hospital payment rates under medical assistance.

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

Sec. 5. Minnesota Statutes 2016, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according to the following:

(1) critical access hospitals as defined by Medicare shall be paid using a cost-based methodology;

(2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology under subdivision 25;

(3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation distinct parts as defined by Medicare shall be paid according to the methodology under subdivision 12; and

(4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

(b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not be rebased, except that a Minnesota long-term hospital shall be rebased effective January 1, 2011, based on its most recent Medicare cost report ending on or before September 1, 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For rate setting periods after November 1, 2014, in which the base years are updated, a Minnesota long-term hospital's base year shall remain within the same period as other hospitals.

(c) Effective for discharges occurring on and after November 1, 2014, payment rates for hospital inpatient services provided by hospitals located in Minnesota or the local trade area, except for the hospitals paid under the methodologies described in paragraph (a), clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a manner similar to Medicare. The base year for the rates effective November 1, 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring that the total aggregate payments under the rebased system are equal to the total aggregate payments that were made for the same number and types of services in the base year. Separate budget neutrality calculations shall be determined for payments made to critical access hospitals and payments made to hospitals paid under the DRG system. Only the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during the entire base period shall be incorporated into the budget neutrality calculation.

(d) For discharges occurring on or after November 1, 2014, through the next rebasing that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph (a), clause (4), shall include adjustments to the projected rates that result in no greater than a five percent increase or decrease from the base year payments for any hospital. Any adjustments to the rates made by the commissioner under this paragraph and paragraph (e) shall maintain budget neutrality as described in paragraph (c).

(e) For discharges occurring on or after November 1, 2014, through the next two rebasing ~~that occurs~~ periods the commissioner may make additional adjustments to the rebased rates, and when evaluating whether additional adjustments should be made, the commissioner shall consider the impact of the rates on the following:

(1) pediatric services;

(2) behavioral health services;

(3) trauma services as defined by the National Uniform Billing Committee;

(4) transplant services;

(5) obstetric services, newborn services, and behavioral health services provided by hospitals outside the seven-county metropolitan area;

(6) outlier admissions;

(7) low-volume providers; and

(8) services provided by small rural hospitals that are not critical access hospitals.

(f) Hospital payment rates established under paragraph (c) must incorporate the following:

(1) for hospitals paid under the DRG methodology, the base year payment rate per admission is standardized by the applicable Medicare wage index and adjusted by the hospital's disproportionate population adjustment;

(2) for critical access hospitals, payment rates for discharges between November 1, 2014, and June 30, 2015, shall be set to the same rate of payment that applied for discharges on October 31, 2014;

(3) the cost and charge data used to establish hospital payment rates must only reflect inpatient services covered by medical assistance; and

(4) in determining hospital payment rates for discharges occurring on or after the rate year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per discharge shall be based on the cost-finding methods and allowable costs of the Medicare

program in effect during the base year or years. In determining hospital payment rates for discharges in subsequent base years, the per discharge rates shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years.

(g) The commissioner shall validate the rates effective November 1, 2014, by applying the rates established under paragraph (c), and any adjustments made to the rates under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the total aggregate payments for the same number and types of services under the rebased rates are equal to the total aggregate payments made during calendar year 2013.

(h) Effective for discharges occurring on or after July 1, 2017, and every two years thereafter, payment rates under this section shall be rebased to reflect only those changes in hospital costs between the existing base year and the next base year. Changes in costs between base years shall be measured using the lower of the hospital cost index defined in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per claim. The commissioner shall establish the base year for each rebasing period considering the most recent year for which filed Medicare cost reports are available. The estimated change in the average payment per hospital discharge resulting from a scheduled rebasing must be calculated and made available to the legislature by January 15 of each year in which rebasing is scheduled to occur, and must include by hospital the differential in payment rates compared to the individual hospital's costs.

(i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates for critical access hospitals located in Minnesota or the local trade area shall be determined using a new cost-based methodology. The commissioner shall establish within the methodology tiers of payment designed to promote efficiency and cost-effectiveness. Payment rates for hospitals under this paragraph shall be set at a level that does not exceed the total cost for critical access hospitals as reflected in base year cost reports. Until the next rebasing that occurs, the new methodology shall result in no greater than a five percent decrease from the base year payments for any hospital, except a hospital that had payments that were greater than 100 percent of the hospital's costs in the base year shall have their rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and after July 1, 2016, covered under this paragraph shall be increased by the inflation factor in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the following criteria:

(1) hospitals that had payments at or below 80 percent of their costs in the base year shall have a rate set that equals 85 percent of their base year costs;

(2) hospitals that had payments that were above 80 percent, up to and including 90 percent of their costs in the base year shall have a rate set that equals 95 percent of their base year costs; and

(3) hospitals that had payments that were above 90 percent of their costs in the base year shall have a rate set that equals 100 percent of their base year costs.

(j) The commissioner may refine the payment tiers and criteria for critical access hospitals to coincide with the next rebasing under paragraph (h). The factors used to develop the new methodology may include, but are not limited to:

(1) the ratio between the hospital's costs for treating medical assistance patients and the hospital's charges to the medical assistance program;

(2) the ratio between the hospital's costs for treating medical assistance patients and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(3) the ratio between the hospital's charges to the medical assistance program and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

(5) the proportion of that hospital's costs that are administrative and trends in administrative costs; and

(6) geographic location.

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

Sec. 6. Minnesota Statutes 2016, section 256.969, is amended by adding a subdivision to read:

Subd. 2e. **Alternate inpatient payment rate.** (a) If the days, costs, and revenues associated with patients who are eligible for medical assistance and also have private health insurance are required to be included in the calculation of the hospital-specific disproportionate share hospital payment limit for a rate year, then the commissioner, effective retroactively to rate years beginning on or after January 1, 2015, shall compute an alternate inpatient payment rate for a Minnesota hospital that is designated as a children's hospital and enumerated as such by Medicare. The commissioner shall reimburse the hospital for a

rate year at the higher of the amount calculated under the alternate payment rate or the amount calculated under subdivision 9.

(b) The alternate payment rate must meet the criteria in clauses (1) to (4):

(1) the alternate payment rate shall be structured to target a total aggregate reimbursement amount equal to two percent less than each children's hospital's cost coverage percentage in the applicable base year for providing fee-for-service inpatient services under this section to patients enrolled in medical assistance;

(2) costs shall be determined using the most recently available medical assistance cost report provided under subdivision 4b, paragraph (a), clause (3), for the applicable base year. Costs shall be determined using standard Medicare cost finding and cost allocation methods and applied in the same manner as the costs were in the rebasing for the applicable base year. If the medical assistance cost report is not available, costs shall be determined in the interim using the Medicare Cost Report;

(3) in any rate year in which payment to a hospital is made using the alternate payment rate, no payments shall be made to the hospital under subdivision 9; and

(4) if the alternate payment amount increases payments at a rate that is higher than the inflation factor applied over the rebasing period, the commissioner shall take this into consideration when setting payment rates at the next rebasing.

Sec. 7. Minnesota Statutes 2016, section 256.969, subdivision 3a, is amended to read:

Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third-party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. Services that have rates established under subdivision ~~11 or~~ 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data

available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates 30 days prior to implementation. The rate setting data must reflect the admissions data used to establish relative values. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by ~~the~~ October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

(b) For fee-for-service admissions occurring on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for inpatient services is reduced by .5 percent from the current statutory rates.

(c) In addition to the reduction in paragraph (b), the total payment for fee-for-service admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph.

(d) In addition to the reduction in paragraphs (b) and (c), the total payment for fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 6.0 percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2006, to reflect this reduction.

(e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 3.46 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced

for services provided on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

(f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2009, through June 30, 2011, to reflect this reduction.

(g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.79 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2011, to reflect this reduction.

(h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total payment for fee-for-service admissions occurring on or after July 1, 2009, made to hospitals for inpatient services before third-party liability and spenddown, is reduced one percent from the current statutory rates. Facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

(i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total payment for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.96 percent from the current statutory rates. Facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2011, to reflect this reduction.

(j) Effective for discharges on and after November 1, 2014, from hospitals paid under subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this subdivision must be incorporated into the rebased rates established under subdivision 2b, paragraph (c), and must not be applied to each claim.

(k) Effective for discharges on and after July 1, 2015, from hospitals paid under subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision must be incorporated into the rates and must not be applied to each claim.

(l) Effective for discharges on and after July 1, 2017, from hospitals paid under subdivision 2b, paragraph (a), clause (2), the rate adjustments in this subdivision must be incorporated into the rates and must not be applied to each claim.

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

Sec. 8. Minnesota Statutes 2016, section 256.969, subdivision 4b, is amended to read:

Subd. 4b. **Medical assistance cost reports for services.** (a) A hospital that meets one of the following criteria must annually submit to the commissioner medical assistance cost reports within six months of the end of the hospital's fiscal year:

(1) a hospital designated as a critical access hospital that receives medical assistance payments; ~~or~~

(2) a Minnesota hospital or out-of-state hospital located within a Minnesota local trade area that receives a disproportionate population adjustment under subdivision 9; or

(3) a Minnesota hospital that is designated as a children's hospital and enumerated as such by Medicare.

For purposes of this subdivision, local trade area has the meaning given in subdivision 17.

(b) The commissioner shall suspend payments to any hospital that fails to submit a report required under this subdivision. Payments must remain suspended until the report has been filed with and accepted by the commissioner.

EFFECTIVE DATE. This section is effective retroactively from January 1, 2015.

Sec. 9. Minnesota Statutes 2016, section 256.969, subdivision 8, is amended to read:

Subd. 8. **Unusual length of stay experience.** (a) The commissioner shall establish day outlier thresholds for each diagnostic category established under subdivision 2 at two standard deviations beyond the mean length of stay. Payment for the days beyond the outlier threshold shall be in addition to the operating and property payment rates per admission established under subdivisions 2 and 2b. Payment for outliers shall be at 70 percent of the allowable operating cost, after adjustment by the case mix index, hospital cost index, relative values and the disproportionate population adjustment. The outlier threshold for neonatal and burn

diagnostic categories shall be established at one standard deviation beyond the mean length of stay, and payment shall be at 90 percent of allowable operating cost calculated in the same manner as other outliers. A hospital may choose an alternative to the 70 percent outlier payment that is at a minimum of 60 percent and a maximum of 80 percent if the commissioner is notified in writing of the request by October 1 of the year preceding the rate year. The chosen percentage applies to all diagnostic categories except burns and neonates. The percentage of allowable cost that is unrecognized by the outlier payment shall be added back to the base year operating payment rate per admission.

(b) Effective for admissions and transfers occurring on and after November 1, 2014, the commissioner shall establish payment rates for outlier payments that are based on Medicare methodologies.

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

Sec. 10. Minnesota Statutes 2016, section 256.969, subdivision 8c, is amended to read:

Subd. 8c. **Hospital residents.** (a) For discharges occurring on or after November 1, 2014, payments for hospital residents shall be made as follows:

(1) payments for the first 180 days of inpatient care shall be the APR-DRG system plus any outliers; and

(2) payment for all medically necessary patient care subsequent to the first 180 days shall be reimbursed at a rate computed by multiplying the statewide average cost-to-charge ratio by the usual and customary charges.

(b) For discharges occurring on or after July 1, 2017, payment for hospital residents shall be equal to the payments under subdivision 8, paragraph (b).

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

Sec. 11. Minnesota Statutes 2016, section 256.969, subdivision 9, is amended to read:

Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.

(b) Certified public expenditures made by Hennepin County Medical Center shall be considered Medicaid disproportionate share hospital payments. Hennepin County and Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning July 1, 2005, or another date specified by the commissioner, that may qualify for reimbursement under federal law. Based on these reports, the commissioner shall apply for federal matching funds.

(c) Upon federal approval of the related state plan amendment, paragraph (b) is effective retroactively from July 1, 2005, or the earliest effective date approved by the Centers for Medicare and Medicaid Services.

(d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid in accordance with a new methodology using 2012 as the base year. Annual payments made under this paragraph shall equal the total amount of payments made for 2012. A licensed children's hospital shall receive only a single DSH factor for children's hospitals. Other DSH factors may be combined to arrive at a single factor for each hospital that is eligible for DSH payments. The new methodology shall make payments only to hospitals located in Minnesota and include the following factors:

(1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000 fee-for-service discharges in the base year shall receive a factor of 0.7880;

(2) a hospital that has in effect for the initial rate year a contract with the commissioner to provide extended psychiatric inpatient services under section 256.9693 shall receive a factor of 0.0160;

(3) a hospital that has received payment from the fee-for-service program for at least 20 transplant services in the base year shall receive a factor of 0.0435;

(4) a hospital that has a medical assistance utilization rate in the base year between 20 percent up to one standard deviation above the statewide mean utilization rate shall receive a factor of 0.0468;

(5) a hospital that has a medical assistance utilization rate in the base year that is at least one standard deviation above the statewide mean utilization rate but is less than three standard deviations above the mean shall receive a factor of 0.2300; and

(6) a hospital that has a medical assistance utilization rate in the base year that is at least three standard deviations above the statewide mean utilization rate shall receive a factor of 0.3711.

(e) Any payments or portion of payments made to a hospital under this subdivision that are subsequently returned to the commissioner because the payments are found to exceed the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the number of fee-for-service discharges, to other DSH-eligible ~~nonchildren's~~ non-children's hospitals that have a medical assistance utilization rate that is at least one standard deviation above the mean.

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

Sec. 12. Minnesota Statutes 2016, section 256.969, subdivision 12, is amended to read:

Subd. 12. **Rehabilitation hospitals and distinct parts.** (a) Units of hospitals that are recognized as rehabilitation distinct parts by the Medicare program shall have separate provider numbers under the medical assistance program for rate establishment and billing purposes only. These units shall also have operating payment rates and the disproportionate population adjustment, if allowed by federal law, established separately from other inpatient hospital services.

(b) The commissioner shall establish separate relative values under subdivision 2 for rehabilitation hospitals and distinct parts as defined by the Medicare program. Effective for discharges occurring on and after November 1, 2014, the commissioner, to the extent possible, shall replicate the existing payment rate methodology under the new diagnostic classification system. The result must be budget neutral, ensuring that the total aggregate

payments under the new system are equal to the total aggregate payments made for the same number and types of services in the base year, calendar year 2012.

(c) For individual hospitals that did not have separate medical assistance rehabilitation provider numbers or rehabilitation distinct parts in the base year, hospitals shall provide the information needed to separate rehabilitation distinct part cost and claims data from other inpatient service data.

(d) Effective with discharges on or after July 1, 2017, payment to rehabilitation hospitals shall be established under subdivision 2b, paragraph (a), clause (4).

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

Sec. 13. Minnesota Statutes 2016, section 256B.04, subdivision 12, is amended to read:

Subd. 12. **Limitation on services.** (a) Place limits on the types of services covered by medical assistance, the frequency with which the same or similar services may be covered by medical assistance for an individual recipient, and the amount paid for each covered service. The state agency shall promulgate rules establishing maximum reimbursement rates for emergency and nonemergency transportation.

The rules shall provide:

(1) an opportunity for all recognized transportation providers to be reimbursed for nonemergency transportation consistent with the maximum rates established by the agency; and

(2) reimbursement of public and private nonprofit providers serving the disabled population generally at reasonable maximum rates that reflect the cost of providing the service regardless of the fare that might be charged by the provider for similar services to individuals other than those receiving medical assistance or medical care under this chapter; ~~and~~.

~~(3) reimbursement for each additional passenger carried on a single trip at a substantially lower rate than the first passenger carried on that trip.~~

(b) The commissioner shall encourage providers reimbursed under this chapter to coordinate their operation with similar services that are operating in the same community. To the extent practicable, the commissioner shall encourage eligible individuals to utilize less expensive providers capable of serving their needs.

(c) For the purpose of this subdivision and section 256B.02, subdivision 8, and effective on January 1, 1981, "recognized provider of transportation services" means an operator of

special transportation service as defined in section 174.29 that has been issued a current certificate of compliance with operating standards of the commissioner of transportation or, if those standards do not apply to the operator, that the agency finds is able to provide the required transportation in a safe and reliable manner. Until January 1, 1981, "recognized transportation provider" includes an operator of special transportation service that the agency finds is able to provide the required transportation in a safe and reliable manner.

Sec. 14. Minnesota Statutes 2016, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine in the same manner as if the service or consultation was delivered in person. Coverage is limited to three telemedicine services per enrollee per calendar week. Telemedicine services shall be paid at the full allowable rate.

(b) The commissioner shall establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service via telemedicine. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide via telemedicine;

(2) has written policies and procedures specific to telemedicine services that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the telemedicine service is rendered;

(4) has established protocols addressing how and when to discontinue telemedicine services; and

(5) has an established quality assurance process related to telemedicine services.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service provided by telemedicine to a medical assistance enrollee. Health care service records for services provided by telemedicine must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service provided by telemedicine;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) the licensed health care provider's basis for determining that telemedicine is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission of the telemedicine service and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's telemedicine consultation with another physician, the written opinion from the consulting physician providing the telemedicine consultation; and

(7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) For purposes of this subdivision, unless otherwise covered under this chapter, "telemedicine" is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

(e) For purposes of this section, "licensed health care provider" ~~is defined~~ means a licensed health care provider under section 62A.671, subdivision 6, and a mental health practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general supervision of a mental health professional; "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

Sec. 15. Minnesota Statutes 2016, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner.

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

(1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals. ~~Over-the-counter medications must be dispensed in a quantity that is the lowest of: (1) the number of dosage units contained in the manufacturer's original package; (2) the number of dosage units required to complete the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed~~

~~from a system using retrospective billing, as provided under subdivision 13e, paragraph (b).~~

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

Sec. 16. Minnesota Statutes 2016, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) Effective April 1, 2017, or upon federal approval, whichever is later, the basis for determining the amount of payment shall be the lower of the ~~actual acquisition costs~~ ingredient cost of the drugs ~~or the maximum allowable cost by the commissioner~~ plus the ~~fixed~~ professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price is defined as the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes those prices the pharmacy charges to customers enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The ~~pharmacy~~ professional dispensing fee shall be ~~$3.65~~ $11.35 for ~~legend prescription drugs~~ prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2), except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be ~~$8~~ $11.35 per bag~~, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed~~

~~in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter~~. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be $11.35 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered outpatient drugs shall be $3.65~~, except that the fee shall be $1.31 for retrospectively billing pharmacies when billing for quantities less than the number of units contained in the manufacturer's original package. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition~~ for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The National Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug ~~shall be estimated by the commissioner at wholesale acquisition cost plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. A "designated rural area" means an area defined as a small rural area or isolated rural area according to the four-category classification of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration. Effective January 1, 2014, the actual acquisition~~. For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient cost at wholesale acquisition cost minus two percent. The commissioner shall establish the ingredient cost of a drug acquired through the federal 340B Drug Pricing Program ~~shall be estimated by the commissioner at wholesale acquisition cost minus 40 percent~~ at a 340B Drug Pricing Program maximum allowable cost. The 340B Drug Pricing Program maximum allowable cost shall be comparable to, but no higher than, the 340B Drug Pricing Program ceiling price established by the Health Resources and Services Administration. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it

shall be comparable to~~, but~~ the actual acquisition cost of the drug product and no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs and no higher than the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) Pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system meeting the requirements of section 151.58, or a packaging system meeting the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ retrospective billing for prescription drugs dispensed to long-term care facility residents. A retrospectively billing pharmacy must submit a claim only for the quantity of medication used by the enrolled recipient during the defined billing period. A retrospectively billing pharmacy must use a billing period not less than one calendar month or 30 days.

(c) ~~An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse.~~ A pharmacy provider using packaging that meets the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(d) ~~Whenever a maximum allowable cost has been set for~~ If a pharmacy dispenses a multisource drug, ~~payment shall be the lower of the usual and customary price charged to the public or~~ the ingredient cost shall be the NADAC of the generic product or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the

provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider, the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. Effective January 1, 2014, the commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by 20 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

(f) The commissioner may ~~negotiate lower reimbursement rates~~ establish maximum allowable cost rates for specialty pharmacy products ~~than the rates~~ that are lower than the ingredient cost formulas specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers ~~with whom the commissioner has negotiated lower reimbursement rates~~ able to provide enhanced clinical services and willing to accept the specialty pharmacy reimbursement. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to ~~this paragraph~~ maximum allowable cost reimbursement. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the ~~reimbursement rate~~ maximum allowable cost to prevent access to care issues.

(g) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

(h) Effective for prescriptions filled on or after April 1, 2017, or upon federal approval, whichever is later, the commissioner shall increase the ingredient cost reimbursement

calculated in paragraphs (a) and (f) by two percent for prescription and nonprescription drugs subject to the wholesale drug distributor tax under section 295.52.

EFFECTIVE DATE. This section is effective retroactively from April 1, 2017, or from the effective date of federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 17. Minnesota Statutes 2016, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service" means motor vehicle transportation provided by a public or private person that serves Minnesota health care program beneficiaries who do not require emergency ambulance service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

(b) Medical assistance covers medical transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, ~~common carrier~~ nonemergency medical transportation company, or other recognized providers of transportation services. Medical transportation must be provided by:

(1) nonemergency medical transportation providers who meet the requirements of this subdivision;

(2) ambulances, as defined in section 144E.001, subdivision 2;

(3) taxicabs that meet the requirements of this subdivision;

(4) public transit, as defined in section 174.22, subdivision 7; or

(5) not-for-hire vehicles, including volunteer drivers.

(c) Medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and in consultation with the Minnesota Department of Transportation. All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

(d) An organization may be terminated, denied, or suspended from enrollment if:

(1) the provider has not initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

(2) the provider has initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

(i) the commissioner has sent the provider a notice that the individual has been disqualified under section 245C.14; and

(ii) the individual has not received a disqualification set-aside specific to the special transportation services provider under sections 245C.22 and 245C.23.

(e) The administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee;

(2) pay nonemergency medical transportation providers for services provided to Minnesota health care programs beneficiaries to obtain covered medical services;

(3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled trips, and number of trips by mode; and

(4) by July 1, 2016, in accordance with subdivision 18e, utilize a Web-based single administrative structure assessment tool that meets the technical requirements established by the commissioner, reconciles trip information with claims being submitted by providers, and ensures prompt payment for nonemergency medical transportation services.

(f) Until the commissioner implements the single administrative structure and delivery system under subdivision 18e, clients shall obtain their level-of-service certificate from the commissioner or an entity approved by the commissioner that does not dispatch rides for clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).

(g) The commissioner may use an order by the recipient's attending physician or a medical or mental health professional to certify that the recipient requires nonemergency medical transportation services. Nonemergency medical transportation providers shall perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

Nonemergency medical transportation providers must take clients to the health care provider using the most direct route, and must not exceed 30 miles for a trip to a primary

care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the local agency.

Nonemergency medical transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Nonemergency medical transportation providers must maintain trip logs, which include pickup and drop-off times, signed by the medical provider or client, whichever is deemed most appropriate, attesting to mileage traveled to obtain covered medical services. Clients requesting client mileage reimbursement must sign the trip log attesting mileage traveled to obtain covered medical services.

(h) The administrative agency shall use the level of service process established by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee to determine the client's most appropriate mode of transportation. If public transit or a certified transportation provider is not available to provide the appropriate service mode for the client, the client may receive a onetime service upgrade.

(i) The covered modes of transportation~~, which may not be implemented without a new rate structure,~~ are:

(1) client reimbursement, which includes client mileage reimbursement provided to clients who have their own transportation, or to family or an acquaintance who provides transportation to the client;

(2) volunteer transport, which includes transportation by volunteers using their own vehicle;

(3) unassisted transport, which includes transportation provided to a client by a taxicab or public transit. If a taxicab or public transit is not available, the client can receive transportation from another nonemergency medical transportation provider;

(4) assisted transport, which includes transport provided to clients who require assistance by a nonemergency medical transportation provider;

(5) lift-equipped/ramp transport, which includes transport provided to a client who is dependent on a device and requires a nonemergency medical transportation provider with a vehicle containing a lift or ramp;

(6) protected transport, which includes transport provided to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety

locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and (ii) who is certified as a protected transport provider; and

(7) stretcher transport, which includes transport for a client in a prone or supine position and requires a nonemergency medical transportation provider with a vehicle that can transport a client in a prone or supine position.

(j) The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the commissioner has developed, made available, and funded the Web-based single administrative structure, assessment tool, and level of need assessment under subdivision 18e. The local agency's financial obligation is limited to funds provided by the state or federal government.

(k) The commissioner shall:

(1) in consultation with the Nonemergency Medical Transportation Advisory Committee, verify that the mode and use of nonemergency medical transportation is appropriate;

(2) verify that the client is going to an approved medical appointment; and

(3) investigate all complaints and appeals.

(l) The administrative agency shall pay for the services provided in this subdivision and seek reimbursement from the commissioner, if appropriate. As vendors of medical care, local agencies are subject to the provisions in section 256B.041, the sanctions and monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

(m) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (h), not the type of vehicle used to provide the service. The medical assistance reimbursement rates for nonemergency medical transportation services that are payable by or on behalf of the commissioner for nonemergency medical transportation services are:

(1) $0.22 per mile for client reimbursement;

(2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer transport;

(3) equivalent to the standard fare for unassisted transport when provided by public transit, and $11 for the base rate and $1.30 per mile when provided by a nonemergency medical transportation provider;

(4) $13 for the base rate and $1.30 per mile for assisted transport;

(5) $18 for the base rate and $1.55 per mile for lift-equipped/ramp transport;

(6) $75 for the base rate and $2.40 per mile for protected transport; and

(7) $60 for the base rate and $2.40 per mile for stretcher transport, and $9 per trip for an additional attendant if deemed medically necessary.

(n) The base rate for nonemergency medical transportation services in areas defined under RUCA to be super rural is equal to 111.3 percent of the respective base rate in paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation services in areas defined under RUCA to be rural or super rural areas is:

(1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage rate in paragraph (m), clauses (1) to (7); and

(2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage rate in paragraph (m), clauses (1) to (7).

(o) For purposes of reimbursement rates for nonemergency medical transportation services under paragraphs (m) and (n), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies.

(p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural.

(q) The commissioner, when determining reimbursement rates for nonemergency medical transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2).

Sec. 18. Minnesota Statutes 2016, section 256B.0625, subdivision 17b, is amended to read:

Subd. 17b. **Documentation required.** (a) As a condition for payment, nonemergency medical transportation providers must document each occurrence of a service provided to a recipient according to this subdivision. Providers must maintain odometer and other records sufficient to distinguish individual trips with specific vehicles and drivers. The documentation may be collected and maintained using electronic systems or software or in paper form but must be made available and produced upon request. Program funds paid for transportation that is not documented according to this subdivision shall be recovered by the department.

(b) A nonemergency medical transportation provider must compile transportation records that meet the following requirements:

(1) the record must be in English and must be legible according to the standard of a reasonable person;

(2) the recipient's name must be on each page of the record; and

(3) each entry in the record must document:

(i) the date on which the entry is made;

(ii) the date or dates the service is provided;

(iii) the printed last name, first name, and middle initial of the driver;

(iv) the signature of the driver attesting to the following: "I certify that I have accurately reported in this record the trip miles I actually drove and the dates and times I actually drove them. I understand that misreporting the miles driven and hours worked is fraud for which I could face criminal prosecution or civil proceedings.";

(v) the signature of the recipient or authorized party attesting to the following: "I certify that I received the reported transportation service.", or the signature of the provider of medical services certifying that the recipient was delivered to the provider;

(vi) the address, or the description if the address is not available, of both the origin and destination, and the mileage for the most direct route from the origin to the destination;

(vii) the mode of transportation in which the service is provided;

(viii) the license plate number of the vehicle used to transport the recipient;

(ix) whether the service was ambulatory or nonambulatory ~~until the modes under subdivision 17 are implemented~~;

(x) the time of the pickup and the time of the drop-off with "a.m." and "p.m." designations;

(xi) the name of the extra attendant when an extra attendant is used to provide special transportation service; and

(xii) the electronic source documentation used to calculate driving directions and mileage.

Sec. 19. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17c. **Nursing facility transports.** A Minnesota health care program enrollee residing in, or being discharged from, a licensed nursing facility is exempt from a level of need determination and is eligible for nonemergency medical transportation services until

the enrollee no longer resides in a licensed nursing facility, as provided in section 256B.04, subdivision 14a.

Sec. 20. Minnesota Statutes 2016, section 256B.0625, subdivision 18h, is amended to read:

Subd. 18h. **Managed care.** (a) The following subdivisions ~~do not~~ apply to managed care plans and county-based purchasing plans:

(1) subdivision 17, paragraphs ~~(d) to (k)~~ (a), (b), (i), and (n);

(2) subdivision ~~18e~~ 18; and

(3) subdivision ~~18g~~ 18a.

(b) A nonemergency medical transportation provider must comply with the operating standards for special transportation service specified in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements in this paragraph.

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

Sec. 21. Minnesota Statutes 2016, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center (FQHC) that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. ~~A federally qualified health center~~ An FQHC that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, ~~a federally qualified health center~~ an FQHC shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. ~~Federally qualified health centers~~ FQHCs that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost

report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), ~~a federally qualified health center~~ an FQHC or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those ~~federally qualified health centers~~ FQHCs and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For ~~federally qualified health centers~~ FQHCs and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not ~~federally qualified health centers~~ FQHCs or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring ~~a federally qualified health center~~ an FQHC or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, through December 31, 2018, each ~~federally qualified health center~~ FQHC and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) Effective for services provided on or after January 1, 2019, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner, according to an annual election by the FQHC or rural health clinic, under the current prospective payment system described in paragraph (f), the alternative payment methodology described in paragraph (f), or the alternative payment methodology described in paragraph (l).

~~(g)~~ (h) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

~~(h)~~ (i) Effective for services provided on or after January 1, 2015, all claims for payment of clinic services provided by ~~federally qualified health centers~~ FQHCs and rural health clinics shall be paid by the commissioner. Effective for services provided on or after January 1, 2015, through July 1, 2017, the commissioner shall determine the most feasible method for paying claims from the following options:

(1) ~~federally qualified health centers~~ FQHCs and rural health clinics submit claims directly to the commissioner for payment, and the commissioner provides claims information for recipients enrolled in a managed care or county-based purchasing plan to the plan, on a regular basis; or

(2) ~~federally qualified health centers~~ FQHCs and rural health clinics submit claims for recipients enrolled in a managed care or county-based purchasing plan to the plan, and those claims are submitted by the plan to the commissioner for payment to the clinic.

Effective for services provided on or after January 1, 2019, FQHCs and rural health clinics shall submit claims directly to the commissioner for payment and the commissioner shall provide claims information for recipients enrolled in a managed care plan or county-based purchasing plan to the plan on a regular basis to be determined by the commissioner.

~~(i)~~ (j) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics, and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1, 2017. Upon final agreement

between the commissioner and a clinic on issues identified under this subdivision, and in accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

~~(j)~~ (k) The commissioner shall seek a federal waiver, authorized under section 1115 of the Social Security Act, to obtain federal financial participation at the 100 percent federal matching percentage available to facilities of the Indian Health Service or tribal organization in accordance with section 1905(b) of the Social Security Act for expenditures made to organizations dually certified under Title V of the Indian Health Care Improvement Act, Public Law 94-437, and as a ~~federally qualified health center~~ FQHC under paragraph (a) that provides services to American Indian and Alaskan Native individuals eligible for services under this subdivision.

(l) Effective for services provided on or after January 1, 2019, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner according to the current prospective payment system described in paragraph (f), or an alternative payment methodology with the following requirements:

(1) each FQHC and rural health clinic must receive a single medical and a single dental organization rate;

(2) the commissioner shall reimburse FQHCs and rural health clinics for allowable costs, including direct patient care costs and patient-related support services, based upon Medicare cost principles that apply at the time the alternative payment methodology is calculated;

(3) the 2019 payment rates for FQHCs and rural health clinics:

(i) must be determined using each FQHC's and rural health clinic's Medicare cost reports from 2015 and 2016. A provider must submit the required cost reports to the commissioner within six months of the second base year calendar or fiscal year end. Cost reports must be submitted six months before the quarter in which the base rate will take effect;

(ii) must be according to current Medicare cost principles applicable to FQHCs and rural health clinics at the time of the alternative payment rate calculation without the application of productivity screens and upper payment limits or the Medicare prospective payment system FQHC aggregate mean upper payment limit; and

(iii) must provide for a 60-day appeals process;

(4) the commissioner shall inflate the base year payment rate for FQHCs and rural health clinics to the effective date by using the Bureau of Economic Analysis's personal consumption expenditures medical care inflator;

(5) the commissioner shall establish a statewide trend inflator using 2015-2020 costs replacing the use of the personal consumption expenditures medical care inflator with the 2023 rate calculation forward;

(6) FQHC and rural health clinic payment rates shall be rebased by the commissioner every two years using the methodology described in clause (3), using the provider's Medicare cost reports from the previous third and fourth years. In nonrebasing years, the commissioner shall adjust using the Medicare economic index until 2023 when the statewide trend inflator is available;

(7) the commissioner shall increase payments by two percent according to Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6. This is an add-on to the rate and must not be included in the base rate calculation;

(8) for FQHCs and rural health clinics seeking a change of scope of services:

(i) the commissioner shall require FQHCs and rural health clinics to submit requests to the commissioner, if the change of scope would result in the medical or dental payment rate currently received by the FQHC or rural health clinic increasing or decreasing by at least 2-1/2 percent;

(ii) FQHCs and rural health clinics shall submit the request to the commissioner within seven business days of submission of the scope change to the federal Health Resources Services Administration;

(iii) the effective date of the payment change is the date the Health Resources Services Administration approves the FQHC's or rural health clinic's change of scope request;

(iv) for change of scope requests that do not require Health Resources Services Administration approval, FQHCs and rural health clinics shall submit the request to the commissioner before implementing the change, and the effective date of the change is the date the commissioner receives the request from the FQHC or rural health clinic; and

(v) the commissioner shall provide a response to the FQHC's or rural health clinic's change of scope request within 45 days of submission and provide a final decision regarding approval or disapproval within 120 days of submission. If more information is needed to evaluate the request, this timeline may be waived by mutual agreement of the commissioner and the FQHC or rural health clinic; and

(9) the commissioner shall establish a payment rate for new FQHC and rural health clinic organizations, considering the following factors:

(i) a comparison of patient caseload of FQHCs and rural health clinics within a 60-mile radius for organizations established outside the seven-county metropolitan area and within a 30-mile radius for organizations within the seven-county metropolitan area; and

(ii) if a comparison is not feasible under item (i), the commissioner may use Medicare cost reports or audited financial statements to establish the base rate.

Sec. 22. Minnesota Statutes 2016, section 256B.0625, subdivision 45a, is amended to read:

Subd. 45a. **Psychiatric residential treatment facility services for persons under 21 years of age.** (a) Medical assistance covers psychiatric residential treatment facility services, according to section 256B.0941, for persons ~~under~~ younger than 21 years of age. Individuals who reach age 21 at the time they are receiving services are eligible to continue receiving services until they no longer require services or until they reach age 22, whichever occurs first.

(b) For purposes of this subdivision, "psychiatric residential treatment facility" means a facility other than a hospital that provides psychiatric services, as described in Code of Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under age 21 in an inpatient setting.

(c) ~~The commissioner shall develop admissions and discharge procedures and establish rates consistent with guidelines from the federal Centers for Medicare and Medicaid Services.~~

~~(d)~~ The commissioner shall enroll up to 150 certified psychiatric residential treatment facility services beds at up to six sites. The commissioner shall select psychiatric residential treatment facility services providers through a request for proposals process. Providers of state-operated services may respond to the request for proposals.

Sec. 23. Minnesota Statutes 2016, section 256B.0625, subdivision 60a, is amended to read:

Subd. 60a. **Community medical response emergency medical technician services.** (a) Medical assistance covers services provided by a community medical response emergency medical technician (CEMT) who is certified under section 144E.275, subdivision 7, when the services are provided in accordance with this subdivision.

(b) A CEMT may provide a ~~posthospital discharge~~ postdischarge visit, after discharge from a hospital or skilled nursing facility, when ordered by a treating physician. The ~~posthospital discharge~~ postdischarge visit includes:

(1) verbal or visual reminders of discharge orders;

(2) recording and reporting of vital signs to the patient's primary care provider;

(3) medication access confirmation;

(4) food access confirmation; and

(5) identification of home hazards.

(c) An individual who has repeat ambulance calls due to falls~~, has been discharged from a nursing home,~~ or has been identified by the individual's primary care provider as at risk for nursing home placement, may receive a safety evaluation visit from a CEMT when ordered by a primary care provider in accordance with the individual's care plan. A safety evaluation visit includes:

(1) medication access confirmation;

(2) food access confirmation; and

(3) identification of home hazards.

(d) A CEMT shall be paid at $9.75 per 15-minute increment. A safety evaluation visit may not be billed for the same day as a ~~posthospital discharge~~ postdischarge visit for the same individual.

Sec. 24. Minnesota Statutes 2016, section 256B.0625, subdivision 64, is amended to read:

Subd. 64. **Investigational drugs, biological products, and devices.** Medical assistance and the early periodic screening, diagnosis, and treatment (EPSDT) program do not cover costs incidental to, associated with, or resulting from the use of investigational drugs, biological products, or devices as defined in section 151.375~~.~~, except that stiripentol may be covered by the EPSDT program, only if all of the following conditions are met:

(1) the use of stiripentol is determined to be medically necessary;

(2) stiripentol is covered only for eligible enrollees with a documented diagnosis of Dravet syndrome, regardless of whether an SCN1A genetic mutation is found, or children with Malignant Migrating Partial Epilepsy in Infancy due to an SCN2A genetic mutation;

(3) all other available covered prescription medications that are medically necessary for the patient have been tried without successful outcomes; and

(4) the United States Food and Drug Administration has approved the treating physician's individual patient investigational new drug application (IND) for the use of stiripentol for treatment.

This provision related to coverage of stiripentol does not apply to MinnesotaCare coverage under chapter 256L.

Sec. 25. Minnesota Statutes 2016, section 256B.0644, is amended to read:

256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.

(a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program and MinnesotaCare as a condition of participating as a provider in health insurance plans and programs or contractor for state employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota Comprehensive Health Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by managed care contracts with the Department of Human Services. This section does not apply to dental service providers providing dental services outside the seven-county metropolitan area.

(b) For providers other than health maintenance organizations, participation in the medical assistance program means that:

(1) the provider accepts new medical assistance and MinnesotaCare patients;

(2) for providers other than dental service providers, at least 20 percent of the provider's patients are covered by medical assistance and MinnesotaCare as their primary source of coverage; or

(3) for dental service providers providing dental services in the seven-county metropolitan area, at least ten percent of the provider's patients are covered by medical assistance and MinnesotaCare as their primary source of coverage, or the provider accepts new medical assistance and MinnesotaCare patients who are children with special health care needs. For purposes of this section, "children with special health care needs" means children up to age 18 who: (i) require health and related services beyond that required by children generally;

and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, including: bleeding and coagulation disorders; immunodeficiency disorders; cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other neurological diseases; visual impairment or deafness; Down syndrome and other genetic disorders; autism; fetal alcohol syndrome; and other conditions designated by the commissioner after consultation with representatives of pediatric dental providers and consumers.

(c) Patients seen on a volunteer basis by the provider at a location other than the provider's usual place of practice may be considered in meeting the participation requirement in this section. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of management and budget, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of management and budget shall implement this section through contracts with participating health and dental carriers.

(d) A volunteer dentist who has signed a volunteer agreement under section 256B.0625, subdivision 9a, shall not be considered to be participating in medical assistance or MinnesotaCare for the purpose of this section.

EFFECTIVE DATE. This section is effective upon receipt of any necessary federal waiver or approval. The commissioner of human services shall notify the revisor of statutes if a federal waiver or approval is sought and, if sought, when a federal waiver or approval is obtained.

Sec. 26. Minnesota Statutes 2016, section 256B.0755, is amended to read:

256B.0755 ~~HEALTH CARE DELIVERY SYSTEMS~~ INTEGRATED HEALTH PARTNERSHIP DEMONSTRATION PROJECT.

Subdivision 1. **Implementation.** (a) The commissioner shall develop and authorize a demonstration project to test alternative and innovative ~~health care delivery systems~~ integrated health partnerships, including accountable care organizations that provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement. The commissioner shall develop a request for proposals for participation in the demonstration project in consultation with hospitals, primary care providers, health plans, and other key stakeholders.

(b) In developing the request for proposals, the commissioner shall:

(1) establish uniform statewide methods of forecasting utilization and cost of care for the appropriate Minnesota public program populations, to be used by the commissioner for ~~the health care delivery system~~ integrated health partnership projects;

(2) identify key indicators of quality, access, patient satisfaction, and other performance indicators that will be measured, in addition to indicators for measuring cost savings;

(3) allow maximum flexibility to encourage innovation and variation so that a variety of provider collaborations are able to become ~~health care delivery systems~~ integrated health partnerships and they can be customized for the special needs and barriers of patient populations experiencing health disparities due to social, economic, racial, or ethnic factors;

(4) encourage and authorize different levels and types of financial risk;

(5) encourage and authorize projects representing a wide variety of geographic locations, patient populations, provider relationships, and care coordination models;

(6) encourage projects that involve close partnerships between the ~~health care delivery system~~ integrated health partnerships and counties and nonprofit agencies that provide services to patients enrolled with the ~~health care delivery system~~ integrated health partnerships, including social services, public health, mental health, community-based services, and continuing care;

(7) encourage projects established by community hospitals, clinics, and other providers in rural communities;

(8) identify required covered services for a total cost of care model or services considered in whole or partially in an analysis of utilization for a risk/gain sharing model;

(9) establish a mechanism to monitor enrollment;

(10) establish quality standards for the ~~delivery system~~ integrated health partnership demonstrations that are appropriate for the particular patient population to be served; and

(11) encourage participation of privately insured population so as to create sufficient alignment in ~~demonstration systems~~ integrated health partnerships.

(c) To be eligible to participate in the demonstration project, ~~a health care delivery system~~ an integrated health partnership must:

(1) provide required covered services and care coordination to recipients enrolled in the ~~health care delivery system~~ integrated health partnership;

(2) establish a process to monitor enrollment and ensure the quality of care provided;

(3) in cooperation with counties and community social service agencies, coordinate the delivery of health care services with existing social services programs;

(4) provide a system for advocacy and consumer protection; and

(5) adopt innovative and cost-effective methods of care delivery and coordination, which may include the use of allied health professionals, telemedicine, patient educators, care coordinators, and community health workers.

(d) ~~A health care delivery system~~ An integrated health partnership demonstration may be formed by the following groups of providers of services and suppliers if they have established a mechanism for shared governance:

(1) professionals in group practice arrangements;

(2) networks of individual practices of professionals;

(3) partnerships or joint venture arrangements between hospitals and health care professionals;

(4) hospitals employing professionals; and

(5) other groups of providers of services and suppliers as the commissioner determines appropriate.

A managed care plan or county-based purchasing plan may participate in this demonstration in collaboration with one or more of the entities listed in clauses (1) to (5).

~~A health care delivery system~~ An integrated health partnership may contract with a managed care plan or a county-based purchasing plan to provide administrative services, including the administration of a payment system using the payment methods established by the commissioner for health care delivery systems.

(e) The commissioner may require ~~a health care delivery system~~ an integrated health partnership to enter into additional third-party contractual relationships for the assessment of risk and purchase of stop loss insurance or another form of insurance risk management related to the delivery of care described in paragraph (c).

Subd. 2. **Enrollment.** (a) Individuals eligible for medical assistance or MinnesotaCare shall be eligible for enrollment in ~~a health care delivery system~~ an integrated health partnership.

(b) Eligible applicants and recipients may enroll in ~~a health care delivery system~~ an integrated health partnership if ~~a system~~ an integrated health partnership serves the county in which the applicant or recipient resides. If more than one ~~health care delivery system~~ integrated health partnership serves a county, the applicant or recipient shall be allowed to choose among the ~~delivery systems~~ integrated health partnerships.

(c) The commissioner may assign an applicant or recipient to ~~a health care delivery system~~ an integrated health partnership if ~~a health care delivery system~~ an integrated health partnership is available and no choice has been made by the applicant or recipient.

Subd. 3. **Accountability.** (a) ~~Health care delivery systems~~ Integrated health partnerships must accept responsibility for the quality of care based on standards established under subdivision 1, paragraph (b), clause (10), and the cost of care or utilization of services provided to its enrollees under subdivision 1, paragraph (b), clause (1). Accountability standards must be appropriate to the particular population served.

(b) ~~A health care delivery system~~ An integrated health partnership may contract and coordinate with providers and clinics for the delivery of services and shall contract with community health clinics, federally qualified health centers, community mental health centers or programs, county agencies, and rural clinics to the extent practicable.

(c) ~~A health care delivery system~~ An integrated health partnership must indicate how it will coordinate with other services affecting its patients' health, quality of care, and cost of care that are provided by other providers, county agencies, and other organizations in the local service area. The ~~health care delivery system~~ integrated health partnership must indicate how it will engage other providers, counties, and organizations, including county-based purchasing plans, that provide services to patients of the ~~health care delivery system~~ integrated health partnership on issues related to local population health, including applicable local needs, priorities, and public health goals. The ~~health care delivery system~~ integrated health partnership must describe how local providers, counties, organizations, including county-based purchasing plans, and other relevant purchasers were consulted in developing the application to participate in the demonstration project.

Subd. 4. **Payment system.** (a) In developing a payment system for ~~health care delivery systems~~ integrated health partnerships, the commissioner shall establish a total cost of care benchmark or a risk/gain sharing payment model to be paid for services provided to the recipients enrolled in ~~a health care delivery system~~ an integrated health partnership.

(b) The payment system may include incentive payments to ~~health care delivery systems~~ integrated health partnerships that meet or exceed annual quality and performance targets realized through the coordination of care.

(c) An amount equal to the savings realized to the general fund as a result of the demonstration project shall be transferred each fiscal year to the health care access fund.

(d) The payment system shall include a population-based payment that supports care coordination services for all enrollees served by the integrated health partnerships, and is risk-adjusted to reflect varying levels of care coordination intensiveness for enrollees with chronic conditions or limited English skills, or who are homeless or experience health disparities or other barriers to health care. The population-based payment shall be a per-member per-month payment paid at least on a quarterly basis. Integrated health partnerships receiving this payment must continue to meet cost and quality metrics under the program to maintain eligibility for the population-based payment. An integrated health partnership is eligible to receive a payment under this paragraph even if the partnership is not participating in a risk-based or gain-sharing payment model and regardless of the size of the patient population served by the integrated health partnership. Any integrated health partnership participant certified as a health care home under section 256B.0751 that agrees to a payment method that includes population-based payments for care coordination is not eligible to receive health care home payment or care coordination fee authorized under section 62U.23 or 256B.0753, subdivision 1, or in-reach care coordination under section 256B.0625, subdivision 56, for any medical assistance or MinnesotaCare recipients enrolled or attributed to the integrated health partnership under this demonstration.

Subd. 5. **Outpatient prescription drug coverage.** Outpatient prescription drug coverage may be provided through accountable care organizations only if the delivery method qualifies for federal prescription drug rebates.

Subd. 6. **Federal approval.** The commissioner shall apply for any federal waivers or other federal approval required to implement this section. The commissioner shall also apply for any applicable grant or demonstration under the Patient Protection and Affordable Health Care Act, Public Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, that would further the purposes of or assist in the establishment of accountable care organizations.

Subd. 7. **Expansion.** The commissioner shall expand the demonstration project to include additional medical assistance and MinnesotaCare enrollees, and shall seek participation of Medicare in demonstration projects. The commissioner shall seek to include participation

of privately insured persons and Medicare recipients in the health care delivery demonstration. As part of the demonstration expansion, the commissioner may procure the services of the health care delivery systems authorized under this section by geographic area, to supplement or replace the services provided by managed care plans operating under section 256B.69.

Sec. 27. **[256B.0759] HEALTH CARE DELIVERY SYSTEMS DEMONSTRATION PROJECT.**

Subdivision 1. **Implementation.** (a) The commissioner shall develop and implement a demonstration project to test alternative and innovative health care delivery system payment and care models that provide services to medical assistance and MinnesotaCare enrollees for an agreed-upon, prospective per capita or total cost of care payment. The commissioner shall implement this demonstration project in coordination with, and as an expansion of, the demonstration project authorized under section 256B.0755.

(b) In developing the demonstration project, the commissioner shall:

(1) establish uniform statewide methods of forecasting utilization and cost of care for the medical assistance and MinnesotaCare populations to be served under the health care delivery system project;

(2) identify key indicators of quality, access, and patient satisfaction, and identify methods to measure cost savings;

(3) allow maximum flexibility to encourage innovation and variation so that a variety of provider collaborations are able to participate as health care delivery systems, and health care delivery systems can be customized to address the special needs and barriers of patient populations;

(4) authorize participation by health care delivery systems representing a variety of geographic locations, patient populations, provider relationships, and care coordination models;

(5) recognize the close partnerships between health care delivery systems and the counties and nonprofit agencies that also provide services to patients enrolled in the health care delivery system, including social services, public health, mental health, community-based services, and continuing care;

(6) identify services to be included under a prospective per capita payment model, and project utilization and cost of these services under a total cost of care risk/gain sharing model;

(7) establish a mechanism to monitor enrollment in each health care delivery system; and

(8) establish quality standards for delivery systems that are appropriate for the specific patient populations served.

Subd. 2. **Requirements for health care delivery systems.** (a) To be eligible to participate in the demonstration project, a health care delivery system must:

(1) provide required services and care coordination to individuals enrolled in the health care delivery system;

(2) establish a process to monitor enrollment and ensure the quality of care provided;

(3) in cooperation with counties and community social service agencies, coordinate the delivery of health care services with existing social services programs;

(4) provide a system for advocacy and consumer protection; and

(5) adopt innovative and cost-effective methods of care delivery and coordination, which may include the use of allied health professionals, telemedicine and patient educators, care coordinators, community paramedics, and community health workers.

(b) A health care delivery system may be formed by the following types of health care providers, if they have established, as applicable, a mechanism for shared governance:

(1) health care providers in group practice arrangements;

(2) networks of health care providers in individual practice;

(3) partnerships or joint venture arrangements between hospitals and health care providers;

(4) hospitals employing or contracting with the necessary range of health care providers; and

(5) other entities, as the commissioner determines appropriate.

(c) A health care delivery system must contract with a third-party administrator to provide administrative services, including the administration of the payment system established under the demonstration project. The third-party administrator must conduct an assessment of risk, and must purchase stop-loss insurance or another form of insurance risk management related to the delivery of care. The commissioner may waive the requirement for contracting with a third-party administrator if the health care delivery system can demonstrate to the commissioner that it can satisfactorily perform all of the duties assigned to the third-party administrator.

Subd. 3. **Enrollment.** (a) Individuals eligible for medical assistance or MinnesotaCare shall be eligible for enrollment in a health care delivery system. Individuals required to enroll in the prepaid medical assistance program or prepaid MinnesotaCare may opt out of receiving care from a managed care or county-based purchasing plan, and elect to receive care through a health care delivery system established under this section.

(b) Eligible applicants and recipients may enroll in a health care delivery system if the system serves the county in which the applicant or recipient resides. If more than one health care delivery system serves a county, the applicant or recipient may choose among the delivery systems. Enrollment in a specific health care delivery system shall be for a 12-month period, except that enrollees who do not maintain eligibility for medical assistance or MinnesotaCare shall be disenrolled, and enrollees experiencing a qualifying life event, as specified by the commissioner, may change health care delivery systems, or opt out of receiving coverage through a health care delivery system, within 60 days of the date of the qualifying life event.

(c) The commissioner shall assign an applicant or recipient to a health care delivery system if:

(1) the applicant or recipient is currently or has recently been attributed to the health care delivery system as part of an integrated health partnership under section 256B.0755; or

(2) no choice has been made by the applicant or recipient. In this case, the commissioner shall enroll an applicant or recipient based on geographic criteria or based on the health care providers from whom the applicant or recipient has received prior care.

Subd. 4. **Accountability.** (a) Health care delivery systems are responsible for the quality of care based on standards established by the commissioner, and for enrollee cost of care and utilization of services. The commissioner shall adjust accountability standards including the quality, cost, and utilization of care to take into account the social, economic, or cultural barriers experienced by the health care delivery system's patient population.

(b) A health care delivery system must contract with community health clinics, federally qualified health centers, community mental health centers or programs, county agencies, and rural health clinics to the extent practicable.

(c) A health care delivery system must indicate to the commissioner how it will coordinate its services with those delivered by other providers, county agencies, and other organizations in the local service area. The health care delivery system must indicate how it will engage other providers, counties, and organizations that provide services to patients of the health

care delivery system on issues related to local population health, including applicable local needs, priorities, and public health goals. The health care delivery system must describe how local providers, counties, and organizations were consulted in developing the application submitted to the commissioner requiring participation in the demonstration project.

Subd. 5. **Payment system.** The commissioner shall develop a payment system for the health care delivery system project that includes prospective per capita payments, total cost of care benchmarks, and risk/gain sharing payment options. The payment system may include incentive payments to health care delivery systems that meet or exceed annual quality and performance targets through the coordination of care.

Subd. 6. **Federal waiver or approval.** The commissioner shall seek all federal waivers or approval necessary to implement the health care delivery system demonstration project. The commissioner shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance of any federal action related to the request for waivers and approval.

EFFECTIVE DATE. This section is effective January 1, 2018, or upon receipt of federal waivers or approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 28. **[256B.0941] PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY FOR PERSONS YOUNGER THAN 21 YEARS OF AGE.**

Subdivision 1. **Eligibility.** (a) An individual who is eligible for mental health treatment services in a psychiatric residential treatment facility must meet all of the following criteria:

(1) before admission, services are determined to be medically necessary by the state's medical review agent according to Code of Federal Regulations, title 42, section 441.152;

(2) is younger than 21 years of age at the time of admission. Services may continue until the individual meets criteria for discharge or reaches 22 years of age, whichever occurs first;

(3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression, or a finding that the individual is a risk to self or others;

(4) has functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; an inability to adequately care for one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill the individual's needs;

(5) requires psychiatric residential treatment under the direction of a physician to improve the individual's condition or prevent further regression so that services will no longer be needed;

(6) utilized and exhausted other community-based mental health services, or clinical evidence indicates that such services cannot provide the level of care needed; and

(7) was referred for treatment in a psychiatric residential treatment facility by a qualified mental health professional licensed as defined in section 245.4871, subdivision 27, clauses (1) to (6).

(b) A mental health professional making a referral shall submit documentation to the state's medical review agent containing all information necessary to determine medical necessity, including a standard diagnostic assessment completed within 180 days of the individual's admission. Documentation shall include evidence of family participation in the individual's treatment planning and signed consent for services.

Subd. 2. **Services.** Psychiatric residential treatment facility service providers must offer and have the capacity to provide the following services:

(1) development of the individual plan of care, review of the individual plan of care every 30 days, and discharge planning by required members of the treatment team according to Code of Federal Regulations, title 42, sections 441.155 to 441.156;

(2) any services provided by a psychiatrist or physician for development of an individual plan of care, conducting a review of the individual plan of care every 30 days, and discharge planning by required members of the treatment team according to Code of Federal Regulations, title 42, sections 441.155 to 441.156;

(3) active treatment seven days per week that may include individual, family, or group therapy as determined by the individual care plan;

(4) individual therapy, provided a minimum of twice per week;

(5) family engagement activities, provided a minimum of once per week;

(6) consultation with other professionals, including case managers, primary care professionals, community-based mental health providers, school staff, or other support planners;

(7) coordination of educational services between local and resident school districts and the facility;

(8) 24-hour nursing; and

(9) direct care and supervision, supportive services for daily living and safety, and positive behavior management.

Subd. 3. **Per diem rate.** (a) The commissioner shall establish a statewide per diem rate for psychiatric residential treatment facility services for individuals 21 years of age or younger. The rate for a provider must not exceed the rate charged by that provider for the same service to other payers. Payment must not be made to more than one entity for each individual for services provided under this section on a given day. The commissioner shall set rates prospectively for the annual rate period. The commissioner shall require providers to submit annual cost reports on a uniform cost reporting form and shall use submitted cost reports to inform the rate-setting process. The cost reporting shall be done according to federal requirements for Medicare cost reports.

(b) The following are included in the rate:

(1) costs necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care, and discharge planning. The direct services costs must be determined using the actual cost of salaries, benefits, payroll taxes, and training of direct services staff and service-related transportation; and

(2) payment for room and board provided by facilities meeting all accreditation and licensing requirements for participation.

(c) A facility may submit a claim for payment outside of the per diem for professional services arranged by and provided at the facility by an appropriately licensed professional who is enrolled as a provider with Minnesota health care programs. Arranged services must be billed by the facility on a separate claim, and the facility shall be responsible for payment to the provider. These services must be included in the individual plan of care and are subject to prior authorization by the state's medical review agent.

(d) Medicaid shall reimburse for concurrent services as approved by the commissioner to support continuity of care and successful discharge from the facility. "Concurrent services" means services provided by another entity or provider while the individual is admitted to a psychiatric residential treatment facility. Payment for concurrent services may be limited and these services are subject to prior authorization by the state's medical review agent. Concurrent services may include targeted case management, assertive community treatment, clinical care consultation, team consultation, and treatment planning.

(e) Payment rates under this subdivision shall not include the costs of providing the following services:

(1) educational services;

(2) acute medical care or specialty services for other medical conditions;

(3) dental services; and

(4) pharmacy drug costs.

(f) For purposes of this section, "actual cost" means costs that are allowable, allocable, reasonable, and consistent with federal reimbursement requirements in Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and the Office of Management and Budget Circular Number A-122, relating to nonprofit entities.

Subd. 4. **Leave days.** (a) Medical assistance covers therapeutic and hospital leave days, provided the recipient was not discharged from the psychiatric residential treatment facility and is expected to return to the psychiatric residential treatment facility. A reserved bed must be held for a recipient on hospital leave or therapeutic leave.

(b) A therapeutic leave day to home shall be used to prepare for discharge and reintegration and shall be included in the individual plan of care. The state shall reimburse 75 percent of the per diem rate for a reserve bed day while the recipient is on therapeutic leave. A therapeutic leave visit may not exceed three days without prior authorization.

(c) A hospital leave day shall be a day for which a recipient has been admitted to a hospital for medical or acute psychiatric care and is temporarily absent from the psychiatric residential treatment facility. The state shall reimburse 50 percent of the per diem rate for a reserve bed day while the recipient is receiving medical or psychiatric care in a hospital.

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

Sec. 29. Minnesota Statutes 2016, section 256B.0943, subdivision 13, is amended to read:

Subd. 13. **Exception to excluded services.** Notwithstanding subdivision 12, up to 15 hours of children's therapeutic services and supports provided within a six-month period to a child with severe emotional disturbance who is residing in a hospital; ~~a group home as defined in Minnesota Rules, parts 2960.0130 to 2960.0220;~~ a residential treatment facility licensed under Minnesota Rules, parts 2960.0580 to 2960.0690; a psychiatric residential treatment facility under section 256B.0625, subdivision 45a; a regional treatment center; or other institutional group setting or who is participating in a program of partial hospitalization are eligible for medical assistance payment if part of the discharge plan.

Sec. 30. Minnesota Statutes 2016, section 256B.0945, subdivision 2, is amended to read:

Subd. 2. **Covered services.** All services must be included in a child's individualized treatment or multiagency plan of care as defined in chapter 245.

For facilities that are not institutions for mental diseases according to federal statute and regulation, medical assistance covers mental health-related services that are required to be provided by a residential facility under section 245.4882 and administrative rules promulgated thereunder, except for room and board. For residential facilities determined by the federal Centers for Medicare and Medicaid Services to be an institution for mental diseases, medical assistance covers medically necessary mental health services provided by the facility according to section 256B.055, subdivision 13, except for room and board.

Sec. 31. Minnesota Statutes 2016, section 256B.0945, subdivision 4, is amended to read:

Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041, payments to counties for residential services provided under this section by a residential facility shall:

(1) for services provided by a residential facility that is not an institution for mental diseases, only be made of federal earnings for services provided ~~under this section~~, and the nonfederal share of costs for services provided under this section shall be paid by the county from sources other than federal funds or funds used to match other federal funds. Payment to counties for services provided according to this section shall be a proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board~~.~~; and

(2) for services provided by a residential facility that is determined to be an institution for mental diseases, be equivalent to the federal share of the payment that would have been made if the residential facility were not an institution for mental diseases. The portion of the payment representing what would be the nonfederal shares shall be paid by the county. Payment to counties for services provided according to this section shall be a proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board.

(b) Per diem rates paid to providers under this section by prepaid plans shall be the proportion of the per-day contract rate that relates to rehabilitative mental health services and shall not include payment for group foster care costs or services that are billed to the county of financial responsibility. Services provided in facilities located in bordering states are eligible for reimbursement on a fee-for-service basis only as described in paragraph (a) and are not covered under prepaid health plans.

(c) Payment for mental health rehabilitative services provided under this section by or under contract with an American Indian tribe or tribal organization or by agencies operated by or under contract with an American Indian tribe or tribal organization must be made according to section 256B.0625, subdivision 34, or other relevant federally approved rate-setting methodology.

(d) The commissioner shall set aside a portion not to exceed five percent of the federal funds earned for county expenditures under this section to cover the state costs of administering this section. Any unexpended funds from the set-aside shall be distributed to the counties in proportion to their earnings under this section.

Sec. 32. Minnesota Statutes 2016, section 256B.15, subdivision 1, is amended to read:

Subdivision 1. **Policy and applicability.** (a) It is the policy of this state that individuals or couples, either or both of whom participate in the medical assistance program, use their own assets to pay their share of the cost of their care during or after their enrollment in the program according to applicable federal law and the laws of this state. The following provisions apply:

(1) subdivisions 1c to 1k shall not apply to claims arising under this section which are presented under section 525.313;

(2) the provisions of subdivisions 1c to 1k expanding the interests included in an estate for purposes of recovery under this section give effect to the provisions of United States Code, title 42, section 1396p, governing recoveries, but do not give rise to any express or implied liens in favor of any other parties not named in these provisions;

(3) the continuation of a recipient's life estate or joint tenancy interest in real property after the recipient's death for the purpose of recovering medical assistance under this section modifies common law principles holding that these interests terminate on the death of the holder;

(4) all laws, rules, and regulations governing or involved with a recovery of medical assistance shall be liberally construed to accomplish their intended purposes;

(5) a deceased recipient's life estate and joint tenancy interests continued under this section shall be owned by the remainderpersons or surviving joint tenants as their interests may appear on the date of the recipient's death. They shall not be merged into the remainder interest or the interests of the surviving joint tenants by reason of ownership. They shall be subject to the provisions of this section. Any conveyance, transfer, sale, assignment, or encumbrance by a remainderperson, a surviving joint tenant, or their heirs, successors, and

assigns shall be deemed to include all of their interest in the deceased recipient's life estate or joint tenancy interest continued under this section; and

(6) the provisions of subdivisions 1c to 1k continuing a recipient's joint tenancy interests in real property after the recipient's death do not apply to a homestead owned of record, on the date the recipient dies, by the recipient and the recipient's spouse as joint tenants with a right of survivorship. Homestead means the real property occupied by the surviving joint tenant spouse as their sole residence on the date the recipient dies and classified and taxed to the recipient and surviving joint tenant spouse as homestead property for property tax purposes in the calendar year in which the recipient dies. For purposes of this exemption, real property the recipient and their surviving joint tenant spouse purchase solely with the proceeds from the sale of their prior homestead, own of record as joint tenants, and qualify as homestead property under section 273.124 in the calendar year in which the recipient dies and prior to the recipient's death shall be deemed to be real property classified and taxed to the recipient and their surviving joint tenant spouse as homestead property in the calendar year in which the recipient dies. The surviving spouse, or any person with personal knowledge of the facts, may provide an affidavit describing the homestead property affected by this clause and stating facts showing compliance with this clause. The affidavit shall be prima facie evidence of the facts it states.

(b) For purposes of this section, "medical assistance" includes the medical assistance program under this chapter, the general assistance medical care program formerly codified under chapter 256D, and alternative care for nonmedical assistance recipients under section 256B.0913.

(c) For purposes of this section, ~~beginning January 1, 2010,~~ "medical assistance" does not include Medicare cost-sharing benefits in accordance with United States Code, title 42, section 1396p.

(d) All provisions in this subdivision, and subdivisions 1d, 1f, 1g, 1h, 1i, and 1j, related to the continuation of a recipient's life estate or joint tenancy interests in real property after the recipient's death for the purpose of recovering medical assistance, are effective only for life estates and joint tenancy interests established on or after August 1, 2003. For purposes of this paragraph, medical assistance does not include alternative care.

EFFECTIVE DATE. This section is effective the day following final enactment and applies retroactively to estate claims pending on or after July 1, 2016, and to the estates of people who died on or after July 1, 2016.

Sec. 33. Minnesota Statutes 2016, section 256B.15, subdivision 1a, is amended to read:

Subd. 1a. **Estates subject to claims.** (a) If a person receives medical assistance hereunder, on the person's death, if single, or on the death of the survivor of a married couple, either or both of whom received medical assistance, or as otherwise provided for in this section, the amount paid for medical assistance as limited under subdivision 2 for the person and spouse shall be filed as a claim against the estate of the person or the estate of the surviving spouse in the court having jurisdiction to probate the estate or to issue a decree of descent according to sections 525.31 to 525.313.

(b) For the purposes of this section, the person's estate must consist of:

(1) the person's probate estate;

(2) all of the person's interests or proceeds of those interests in real property the person owned as a life tenant or as a joint tenant with a right of survivorship at the time of the person's death;

(3) all of the person's interests or proceeds of those interests in securities the person owned in beneficiary form as provided under sections 524.6-301 to 524.6-311 at the time of the person's death, to the extent the interests or proceeds of those interests become part of the probate estate under section 524.6-307;

(4) all of the person's interests in joint accounts, multiple-party accounts, and pay-on-death accounts, brokerage accounts, investment accounts, or the proceeds of those accounts, as provided under sections 524.6-201 to 524.6-214 at the time of the person's death to the extent the interests become part of the probate estate under section 524.6-207; and

(5) assets conveyed to a survivor, heir, or assign of the person through survivorship, living trust, or other arrangements.

(c) For the purpose of this section and recovery in a surviving spouse's estate for medical assistance paid for a predeceased spouse, the estate must consist of all of the legal title and interests the deceased individual's predeceased spouse had in jointly owned or marital property at the time of the spouse's death, as defined in subdivision 2b, and the proceeds of those interests, that passed to the deceased individual or another individual, a survivor, an heir, or an assign of the predeceased spouse through a joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. A deceased recipient who, at death, owned the property jointly with the surviving spouse shall have an interest in the entire property.

(d) For the purpose of recovery in a single person's estate or the estate of a survivor of a married couple, "other arrangement" includes any other means by which title to all or any part of the jointly owned or marital property or interest passed from the predeceased spouse to another including, but not limited to, transfers between spouses which are permitted, prohibited, or penalized for purposes of medical assistance.

(e) A claim shall be filed if medical assistance was rendered for either or both persons under one of the following circumstances:

~~(1) the person was over 55 years of age, and received services under this chapter prior to January 1, 2014;~~

~~(2)~~ (1) the person resided in a medical institution for six months or longer, received services under this chapter, and, at the time of institutionalization or application for medical assistance, whichever is later, the person could not have reasonably been expected to be discharged and returned home, as certified in writing by the person's treating physician. For purposes of this section only, a "medical institution" means a skilled nursing facility, intermediate care facility, intermediate care facility for persons with developmental disabilities, nursing facility, or inpatient hospital;

~~(3)~~ (2) the person received general assistance medical care services under the program formerly codified under chapter 256D; or

~~(4)~~ (3) the person was 55 years of age or older and received medical assistance services ~~on or after January 1, 2014,~~ that consisted of nursing facility services, home and community-based services, or related hospital and prescription drug benefits.

(f) The claim shall be considered an expense of the last illness of the decedent for the purpose of section 524.3-805. Notwithstanding any law or rule to the contrary, a state or county agency with a claim under this section must be a creditor under section 524.6-307. Any statute of limitations that purports to limit any county agency or the state agency, or both, to recover for medical assistance granted hereunder shall not apply to any claim made hereunder for reimbursement for any medical assistance granted hereunder. Notice of the claim shall be given to all heirs and devisees of the decedent, and to other persons with an ownership interest in the real property owned by the decedent at the time of the decedent's death, whose identity can be ascertained with reasonable diligence. The notice must include procedures and instructions for making an application for a hardship waiver under subdivision 5; time frames for submitting an application and determination; and information regarding appeal rights and procedures. Counties are entitled to one-half of the nonfederal share of medical assistance collections from estates that are directly attributable to county effort.

Counties are entitled to ten percent of the collections for alternative care directly attributable to county effort.

EFFECTIVE DATE. This section is effective the day following final enactment and applies retroactively to estate claims pending on or after July 1, 2016, and to the estates of people who died on or after July 1, 2016.

Sec. 34. Minnesota Statutes 2016, section 256B.15, subdivision 2, is amended to read:

Subd. 2. **Limitations on claims.** ~~(a) For services rendered prior to January 1, 2014, the claim shall include only the total amount of medical assistance rendered after age 55 or during a period of institutionalization described in subdivision 1a, paragraph (e), and the total amount of general assistance medical care rendered under the program formerly codified under chapter 256D, and shall not include interest.~~

~~(b) For services rendered on or after January 1, 2014,~~ (a) The claim shall include only:

(1) the amount of medical assistance rendered to recipients 55 years of age or older ~~and~~ that consisted of nursing facility services, home and community-based services, and related hospital and prescription drug services; ~~and~~

(2) the total amount of medical assistance rendered during a period of institutionalization described in subdivision 1a, paragraph (e), clause ~~(2).~~ (1); and

(3) the total amount of general assistance medical care rendered under the program formerly codified under chapter 256D.

The claim shall not include interest. For the purposes of this section, "home and community-based services" has the same meaning it has when used in United States Code, title 42, section 1396p(b)(1)(B)(i), and includes the alternative care program under section 256B.0913, even for periods when alternative care services receive only state funding.

~~(c)~~ (b) Claims that have been allowed but not paid shall bear interest according to section 524.3-806, paragraph (d). A claim against the estate of a surviving spouse who did not receive medical assistance, for medical assistance rendered for the predeceased spouse, shall be payable from the full value of all of the predeceased spouse's assets and interests which are part of the surviving spouse's estate under subdivisions 1a and 2b. Recovery of medical assistance expenses in the nonrecipient surviving spouse's estate is limited to the value of the assets of the estate that were marital property or jointly owned property at any time during the marriage. The claim is not payable from the value of assets or proceeds of assets in the estate attributable to a predeceased spouse whom the individual married after the death of the predeceased recipient spouse for whom the claim is filed or from assets and

the proceeds of assets in the estate which the nonrecipient decedent spouse acquired with assets which were not marital property or jointly owned property after the death of the predeceased recipient spouse. Claims for alternative care shall be net of all premiums paid under section 256B.0913, subdivision 12, on or after July 1, 2003, and shall be limited to services provided on or after July 1, 2003. Claims against marital property shall be limited to claims against recipients who died on or after July 1, 2009.

EFFECTIVE DATE. This section is effective the day following final enactment and applies retroactively to estate claims pending on or after July 1, 2016, and to the estates of people who died on or after July 1, 2016.

Sec. 35. Minnesota Statutes 2016, section 256B.196, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital services upper payment limit for nonstate government hospitals. The commissioner shall then determine the amount of a supplemental payment to Hennepin County Medical Center and Regions Hospital for these services that would increase medical assistance spending in this category to the aggregate upper payment limit for all nonstate government hospitals in Minnesota. In making this determination, the commissioner shall allot the available increases between Hennepin County Medical Center and Regions Hospital based on the ratio of medical assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner shall adjust this allotment as necessary based on federal approvals, the amount of intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors, in order to maximize the additional total payments. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match federal Medicaid payments available under this subdivision in order to make supplementary medical assistance payments to Hennepin County Medical Center and Regions Hospital equal to an amount that when combined with existing medical assistance payments to nonstate governmental hospitals would increase total payments to hospitals in this category for outpatient services to the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center and Regions Hospital.

(b) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians and other billing professionals affiliated with Hennepin County Medical Center and with Regions Hospital. The upper payment limit shall be based on the average commercial rate or be determined using another method

acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and to make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group equal to the difference between the established medical assistance payment for physician and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and shall make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group.

(c) Beginning January 1, 2010, Hennepin County and Ramsey County may make monthly voluntary intergovernmental transfers to the commissioner in amounts not to exceed $12,000,000 per year from Hennepin County and $6,000,000 per year from Ramsey County. The commissioner shall increase the medical assistance capitation payments to any licensed health plan under contract with the medical assistance program that agrees to make enhanced payments to Hennepin County Medical Center or Regions Hospital. The increase shall be in an amount equal to the annual value of the monthly transfers plus federal financial participation, with each health plan receiving its pro rata share of the increase based on the pro rata share of medical assistance admissions to Hennepin County Medical Center and Regions Hospital by those plans. Upon the request of the commissioner, health plans shall submit individual-level cost data for verification purposes. The commissioner may ratably reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed health plan that receives increased medical assistance capitation payments under the intergovernmental transfer described in this paragraph shall increase its medical assistance payments to Hennepin County Medical Center and Regions Hospital by the same amount as the increased payments received in the capitation payment described in this paragraph.

(d) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for ambulance services affiliated with Hennepin County Medical Center and the city of St. Paul, and ambulance services owned and operated by another governmental entity that chooses to participate by requesting the commissioner to determine an upper payment limit. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for

Medicare and Medicaid Services. The commissioner shall inform Hennepin County ~~and~~, the city of St. Paul, and other participating governmental entities of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to Hennepin County Medical Center ~~and~~, the city of St. Paul, and other participating governmental entities equal to the difference between the established medical assistance payment for ambulance services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center ~~and~~, the city of St. Paul~~.~~, and other participating governmental entities. A tribal government that owns and operates an ambulance service is not eligible to participate under this subdivision.

(e) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians, dentists, and other billing professionals affiliated with the University of Minnesota and University of Minnesota Physicians. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform the University of Minnesota Medical School and University of Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians equal to the difference between the established medical assistance payment for physician, dentist, and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians.

(f) Beginning January 1, 2018, the University of Minnesota Medical School and the University of Minnesota School of Dentistry may make monthly voluntary intergovernmental transfers to the commissioner in amounts not to exceed $20,000,000 per year from the University of Minnesota Medical School and $6,000,000 per year from the University of Minnesota School of Dentistry. The commissioner shall increase the medical assistance capitation payments to any licensed health plan under contract with the medical assistance program that agrees to make enhanced payments to the University of Minnesota and the University of Minnesota Physicians. The increase shall be in an amount equal to the annual value of the monthly transfers plus federal financial participation, with each health plan receiving its pro rata share of the increase based on the pro rata share of medical assistance

services by physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians. Upon the request of the commissioner, health plans shall submit individual-level cost data for verification purposes. The commissioner may ratably reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed health plan that receives increased medical assistance capitation payments under the intergovernmental transfer described in this paragraph shall increase its medical assistance payments to the University of Minnesota and the University of Minnesota Physicians by the same amount as the increased payments received in the capitation payment described in this paragraph.

(g) The commissioner shall inform the transferring governmental entities on an ongoing basis of the need for any changes needed in the intergovernmental transfers in order to continue the payments under paragraphs (a) to ~~(d)~~ (f), at their maximum level, including increases in upper payment limits, changes in the federal Medicaid match, and other factors.

~~(f)~~ (h) The payments in paragraphs (a) to ~~(d)~~ (f) shall be implemented independently of each other, subject to federal approval and to the receipt of transfers under subdivision 3.

(i) All of the data and funding transactions related to the payments in paragraphs (a) to (f) shall be between the commissioner and the governmental entities.

EFFECTIVE DATE. Paragraph (d) is effective July 1, 2017, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is received.

Sec. 36. Minnesota Statutes 2016, section 256B.196, subdivision 3, is amended to read:

Subd. 3. **Intergovernmental transfers.** Based on the determination by the commissioner under subdivision 2, Hennepin County and Ramsey County shall make periodic intergovernmental transfers to the commissioner for the purposes of subdivision 2, paragraphs (a) and (b). All of the intergovernmental transfers made by Hennepin County shall be used to match federal payments to Hennepin County Medical Center under subdivision 2, paragraph (a), and to physicians and other billing professionals affiliated with Hennepin County Medical Center under subdivision 2, paragraph (b). All of the intergovernmental transfers made by Ramsey County shall be used to match federal payments to Regions Hospital under subdivision 2, paragraph (a), and to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group under subdivision 2, paragraph (b). All of the intergovernmental transfer payments made by the University of Minnesota Medical School and the University of Minnesota School of Dentistry shall be

used to match federal payments to the University of Minnesota and the University of Minnesota Physicians under subdivision 2, paragraphs (e) and (f).

Sec. 37. Minnesota Statutes 2016, section 256B.196, subdivision 4, is amended to read:

Subd. 4. **Adjustments permitted.** (a) The commissioner may adjust the intergovernmental transfers under subdivision 3 and the payments under subdivision 2, based on the commissioner's determination of Medicare upper payment limits, hospital-specific charge limits, hospital-specific limitations on disproportionate share payments, medical inflation, actuarial certification, average commercial rates for physician and other professional services, and cost-effectiveness for purposes of federal waivers. Any adjustments must be made on a proportional basis. The commissioner may make adjustments under this subdivision only after consultation with the affected counties, university schools, and hospitals. All payments under subdivision 2 and all intergovernmental transfers under subdivision 3 are limited to amounts available after all other base rates, adjustments, and supplemental payments in chapter 256B are calculated.

(b) The ratio of medical assistance payments specified in subdivision 2 to the voluntary intergovernmental transfers specified in subdivision 3 shall not be reduced except as provided under paragraph (a).

Sec. 38. Minnesota Statutes 2016, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract

effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) The commissioner shall require that managed care plans use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659.

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(f) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous calendar year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospital admission rate compared to the hospital admission rates in calendar year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting

this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(g) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(h) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(i) Effective for services rendered on or after January 1, 2014, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July

31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(j) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

(k) Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

(l) The return of the withhold under paragraphs (h) and (i) is not subject to the requirements of paragraph (c).

(m) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

(n) Effective for services provided on or after January 1, 2018, through December 31, 2018, the commissioner shall withhold two percent of the capitation payment provided to managed care plans under this section, and county-based purchasing plans under section 256B.692, for each medical assistance enrollee. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year, for capitation payments for enrollees for whom the plan has submitted to the commissioner a verification of coverage form completed and signed by the enrollee. The verification of coverage form must be developed by the commissioner and made available to managed care and county-based purchasing plans. The form must require the enrollee to provide the enrollee's name, street address, and the name of the managed care or county-based purchasing plan selected by or assigned to the enrollee, and must include a signature block that allows the enrollee to attest that the information provided is accurate. A plan shall request that all enrollees complete the verification of coverage form, and shall submit all completed forms to the commissioner

by February 28, 2018. If a completed form for an enrollee is not received by the commissioner by that date:

(1) the commissioner shall not return to the plan funds withheld for that enrollee;

(2) the commissioner shall cease making capitation payments to the plan for that enrollee, effective with the April 2018 coverage month; and

(3) the commissioner shall disenroll the enrollee from medical assistance, subject to any enrollee appeal.

Sec. 39. Minnesota Statutes 2016, section 256B.69, is amended by adding a subdivision to read:

Subd. 36. **Competitive bidding and procurement.** (a) For managed care organization contracts effective on or after January 1, 2019, the commissioner shall utilize a competitive price and technical bidding program on a regional basis for nonelderly adults and children who are not eligible on the basis of a disability and are enrolled in medical assistance and MinnesotaCare. If the commissioner utilizes a competitive price bidding program, the commissioner shall establish geographic regions for the purposes of competitive price bidding. The commissioner shall not implement a competitive price bidding program for more than 40 percent of the regions during each procurement. The commissioner shall ensure that there is an adequate choice of managed care organizations based on the potential enrollment, in a manner that is consistent with the requirements of section 256B.694. The commissioner shall operate the competitive bidding program by region, but shall award contracts by county and shall allow managed care organizations with a service area consisting of only a portion of a region to bid on those counties within their service area only. For purposes of this subdivision, "managed care organization" means a demonstration provider as defined in subdivision 2, paragraph (b).

(b) The commissioner shall provide the scoring weight of selection criteria to be assigned in the procurement process and include the scoring weight in the request for proposals. Substantial weight shall be given to county board resolutions and priority areas identified by counties.

(c) If a best and final offer is requested, each responding managed care organization must be offered the opportunity to submit a best and final offer.

(d) The commissioner, when evaluating proposals, shall consider network adequacy for dental and other services.

(e) Notwithstanding sections 13.591 and 13.599, after the managed care organizations are notified about the award determination, but before contracts are signed, the commissioner shall provide each managed care organization with its own scoring sheet and supporting information. The scoring sheet shall not be made available to other managed care organizations until final contracts are signed.

(f) A managed care organization that is aggrieved by the commissioner's decision related to the selection of managed care organizations to deliver services in a county or counties may appeal the commissioner's decision using the process outlined in section 256B.69, subdivision 3a, paragraph (d), except that the recommendation of the three-person mediation panel shall be binding on the commissioner.

(g) The commissioner shall contract for an independent evaluation of the competitive price bidding process. The contractor must solicit recommendations from all parties participating in the competitive price bidding process for service delivery in calendar year 2019 on how the competitive price bidding process may be improved for service delivery in calendar year 2020 and annually thereafter. The commissioner shall make evaluation results available to the public on the department's Web site.

Sec. 40. Minnesota Statutes 2016, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under this paragraph for the applicable payment year shall be the final payment and shall not be settled to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal year ending in 2016, the rate for outpatient hospital services shall be computed using information from each hospital's Medicare cost report as filed with Medicare for the year that is two years before the year that the rate is being computed. Rates shall be computed using information from Worksheet C series until the department finalizes the medical assistance cost reporting process for critical access hospitals. After the cost reporting process is finalized, rates shall be computed using information from Title XIX Worksheet D series. The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs related to rural health clinics and federally qualified health clinics, divided by ancillary charges plus outpatient charges, excluding charges related to rural health clinics and federally qualified health clinics.

(c) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2003 legislature to define and implement this provision.

(d) For fee-for-service services provided on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for outpatient hospital facility services is reduced by .5 percent from the current statutory rate.

(e) In addition to the reduction in paragraph (d), the total payment for fee-for-service services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

(f) In addition to the reductions in paragraphs (d) and (e), the total payment for fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced three percent from the current statutory rates. Mental health services and facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

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

Sec. 41. **[256B.7635] REIMBURSEMENT FOR EVIDENCE-BASED PUBLIC HEALTH NURSE HOME VISITS.**

Effective for services provided on or after January 1, 2018, prenatal and postpartum follow-up home visits provided by public health nurses or registered nurses supervised by a public health nurse using evidence-based models shall be paid a minimum of $140 per visit. Evidence-based postpartum follow-up home visits must be administered by home visiting programs that meet the United States Department of Health and Human Services criteria for evidence-based models and are identified by the commissioner of health as eligible to be implemented under the Maternal, Infant, and Early Childhood Home Visiting program. Home visits must target mothers and their children beginning with prenatal visits through age three for the child.

Sec. 42. Minnesota Statutes 2016, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

(a) Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and related services as basic care services. The reduction in this paragraph shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

(b) Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction effective July 1, 2010.

(c) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

(d) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable

medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, and anesthesia services shall be reduced by three percent from the rates in effect on August 31, 2011.

(e) Effective for services provided on or after September 1, 2014, payments for ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory services, public health nursing services, eyeglasses not subject to a volume purchase contract, and hearing aids not subject to a volume purchase contract shall be increased by three percent and payments for outpatient hospital facility fees shall be increased by three percent. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(f) Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2015, shall be increased by three percent from the rates as determined under paragraphs (i) and (j).

(g) Effective for services provided on or after July 1, 2015, payments for outpatient hospital facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, and laboratory services to a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(h) This section does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.

(i) Effective for services provided on or after July 1, 2015, the following categories of medical supplies and durable medical equipment shall be individually priced items: enteral nutrition and supplies, customized and other specialized tracheostomy tubes and supplies, electric patient lifts, and durable medical equipment repair and service. This paragraph does

not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, and items provided to dually eligible recipients when Medicare is the primary payer for the item. The commissioner shall not apply any medical assistance rate reductions to durable medical equipment as a result of Medicare competitive bidding.

(j) Effective for services provided on or after July 1, 2015, medical assistance payment rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased as follows:

(1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that were subject to the Medicare competitive bid that took effect in January of 2009 shall be increased by 9.5 percent; and

(2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on the medical assistance fee schedule, whether or not subject to the Medicare competitive bid that took effect in January of 2009, shall be increased by 2.94 percent, with this increase being applied after calculation of any increased payment rate under clause (1).

This paragraph does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, items provided to dually eligible recipients when Medicare is the primary payer for the item, and individually priced items identified in paragraph (i). Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect the rate increases in this paragraph.

(k) Effective for nonpressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the submitted charge or the Medicare fee schedule rate. Effective for pressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the submitted charge or 47 percent above the Medicare fee schedule rate.

EFFECTIVE DATE. This section is effective retroactively from January 1, 2016.

Sec. 43. **[256B.90] DEFINITIONS.**

Subdivision 1. **Generally.** For the purposes of sections 256B.90 to 256B.92, the following terms have the meanings given.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 3. **Department.** "Department" means the Department of Human Services.

Subd. 4. **Hospital.** "Hospital" means a public or private institution licensed as a hospital under section 144.50 that participates in medical assistance.

Subd. 5. **Medical assistance.** "Medical assistance" means the state's Medicaid program under title XIX of the Social Security Act and administered according to this chapter.

Subd. 6. **Potentially avoidable complication.** "Potentially avoidable complication" means a harmful event or negative outcome with respect to an individual, including an infection or surgical complication, that: (1) occurs after the individual's admission to a hospital or long-term care facility; and (2) may have resulted from the care, lack of care, or treatment provided during the hospital or long-term care facility stay rather than from a natural progression of an underlying disease.

Subd. 7. **Potentially avoidable event.** "Potentially avoidable event" means a potentially avoidable complication, potentially avoidable readmission, or a combination of those events.

Subd. 8. **Potentially avoidable readmission.** "Potentially avoidable readmission" means a return hospitalization of an individual within a period specified by the commissioner that may have resulted from deficiencies in the care or treatment provided to the individual during a previous hospital stay or from deficiencies in posthospital discharge follow-up. Potentially avoidable readmission does not include a hospital readmission necessitated by the occurrence of unrelated events after the discharge. Potentially avoidable readmission includes the readmission of an individual to a hospital for: (1) the same condition or procedure for which the individual was previously admitted; (2) an infection or other complication resulting from care previously provided; or (3) a condition or procedure that indicates that a surgical intervention performed during a previous admission was unsuccessful in achieving the anticipated outcome.

Sec. 44. **[256B.91] MEDICAL ASSISTANCE OUTCOMES-BASED PAYMENT PROGRAM.**

Subdivision 1. **Generally.** The commissioner must establish and implement a medical assistance outcomes-based payment program as a hospital outcomes program under section 256B.92 to provide hospitals with information and incentives to reduce potentially avoidable events.

Subd. 2. **Potentially avoidable event methodology.** (a) The commissioner shall issue a request for proposals to select a methodology for identifying potentially avoidable events and for the costs associated with these events, and for measuring hospital performance with respect to these events.

(b) The commissioner shall develop definitions for each potentially avoidable event according to the selected methodology.

(c) To the extent possible, the methodology shall be one that has been used by other title XIX programs under the Social Security Act or by commercial payers in health care outcomes performance measurement and in outcome-based payment programs. The methodology shall be open, transparent, and available for review by the public.

Subd. 3. **Medical assistance system waste.** (a) The commissioner must conduct a comprehensive analysis of relevant state databases to identify waste in the medical assistance system.

(b) The analysis must identify instances of potentially avoidable events in medical assistance, and the costs associated with these events. The overall estimate of waste must be broken down into actionable categories including but not limited to regions, hospitals, MCOs, physicians, service lines, diagnosis-related groups, medical conditions and procedures, patient characteristics, provider characteristics, and medical assistance program type.

(c) Information collected from this analysis must be utilized in hospital outcomes programs described in this section.

Sec. 45. **[256B.92] HOSPITAL OUTCOMES PROGRAM.**

Subdivision 1. **Generally.** The hospital outcomes program shall:

(1) target reduction of potentially avoidable readmissions and complications;

(2) apply to all state acute care hospitals participating in medical assistance. Program adjustments may be made for certain types of hospitals; and

(3) be implemented in two phases: performance reporting and outcomes-based financial incentives.

Subd. 2. **Phase 1; performance reporting.** (a) The commissioner shall develop and maintain a reporting system to provide each hospital in Minnesota with regular confidential reports regarding the hospital's performance for potentially avoidable readmissions and potentially avoidable complications.

(b) The commissioner shall:

(1) conduct ongoing analyses of relevant state claims databases to identify instances of potentially avoidable readmissions and potentially avoidable complications, and the expenditures associated with these events;

(2) create or locate state readmission and complications norms;

(3) measure actual-to-expected hospital performance compared to state norms;

(4) compare hospitals with peers using risk adjustment procedures that account for the severity of illness of each hospital's patients;

(5) distribute reports to hospitals to provide actionable information to create policies, contracts, or programs designed to improve target outcomes; and

(6) foster collaboration among hospitals to share best practices.

(c) A hospital may share the information contained in the outcome performance reports with physicians and other health care providers providing services at the hospital to foster coordination and cooperation in the hospital's outcome improvement and waste reduction initiatives.

Subd. 3. **Phase 2; outcomes-based financial incentives.** Twelve months after implementation of performance reporting under subdivision 2, the commissioner must establish financial incentives for a hospital to reduce potentially avoidable readmissions and potentially avoidable complications.

Subd. 4. **Rate adjustment methodology.** (a) The commissioner must adjust the reimbursement that a hospital receives under the All Patients Refined Diagnosis-Related Group inpatient prospective payment system based on the hospital's performance exceeding, or failing to achieve, outcome results based on the rates of potentially avoidable readmissions and potentially avoidable complications.

(b) The rate adjustment methodology must:

(1) apply to each hospital discharge;

(2) determine a hospital-specific potentially avoidable outcome adjustment factor based on the hospital's actual versus expected risk-adjusted performance compared to the state norm;

(3) be based on a retrospective analysis of performance prospectively applied;

(4) include both rewards and penalties; and

(5) be communicated to a hospital in a clear and transparent manner.

Subd. 5. **Amendment of contracts.** The commissioner must amend contracts with participating hospitals as necessary to incorporate the financial incentives established under this section.

Subd. 6. **Budget neutrality.** The hospital outcomes program shall be implemented in a budget-neutral manner with respect to aggregate Medicaid hospital expenditures.

Sec. 46. Minnesota Statutes 2016, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly individual or family income.

(b) Beginning ~~January 1, 2014~~ October 1, 2017, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d).

(c) Paragraph (b) does not apply to:

(1) children 20 years of age or younger; and

(2) individuals with household incomes below 35 percent of the federal poverty guidelines.

(d) The following premium scale is established for each individual in the household who is 21 years of age or older and enrolled in MinnesotaCare:

Federal Poverty Guideline Greater than or Equal to	**Less than**	**Individual Premium Amount**
		~~$4~~
35%	55%	$5
		~~$6~~
55%	80%	$7
		~~$8~~
80%	90%	$11
		~~$10~~
90%	100%	$12
		~~$12~~
100%	110%	$13
		~~$14~~
110%	120%	$15
		~~$15~~
120%	130%	$16
		~~$16~~
130%	140%	$18
		~~$25~~
140%	150%	$32
		~~$29~~
150%	160%	$40

			~~$33~~
	160%	170%	$48
			~~$38~~
	170%	180%	$56
			~~$43~~
	180%	190%	$65
			~~$50~~
	190%		$75
	200%		$85

Sec. 47. **CAPITATION PAYMENT DELAY.**

(a) The commissioner of human services shall delay $135,000,000 of the medical assistance and MinnesotaCare capitation payment to managed care plans and county-based purchasing plans due in May 2019 and the payment due in April 2019 for special needs basic care until July 1, 2019. The payment shall be made no earlier than July 1, 2019, and no later than July 31, 2019.

(b) The commissioner of human services shall delay $135,000,000 of the medical assistance and MinnesotaCare capitation payment to managed care plans and county-based purchasing plans due in the second quarter of calendar year 2021 and the April 2021 payment for special needs basic care until July 1, 2021. The payment shall be made no earlier than July 1, 2021, and no later than July 31, 2021.

Sec. 48. **CHILDREN'S MENTAL HEALTH REPORT AND RECOMMENDATIONS.**

The commissioner of human services shall conduct a comprehensive analysis of Minnesota's continuum of intensive mental health services and shall develop recommendations for a sustainable and community-driven continuum of care for children with serious mental health needs, including children currently being served in residential treatment. The commissioner's analysis shall include, but not be limited to:

(1) data related to access, utilization, efficacy, and outcomes for Minnesota's current system of residential mental health treatment for a child with a severe emotional disturbance;

(2) potential expansion of the state's psychiatric residential treatment facility (PRTF) capacity, including increasing the number of PRTF beds and conversion of existing children's mental health residential treatment programs into PRTFs;

(3) the capacity need for PRTF and other group settings within the state if adequate community-based alternatives are accessible, equitable, and effective statewide;

(4) recommendations for expanding alternative community-based service models to meet the needs of a child with a serious mental health disorder who would otherwise require residential treatment and potential service models that could be utilized, including data related to access, utilization, efficacy, and outcomes;

(5) models of care used in other states; and

(6) analysis and specific recommendations for the design and implementation of new service models, including analysis to inform rate setting as necessary.

The analysis shall be supported and informed by extensive stakeholder engagement. Stakeholders include individuals who receive services, family members of individuals who receive services, providers, counties, health plans, advocates, and others. Stakeholder engagement shall include interviews with key stakeholders, intentional outreach to individuals who receive services and the individual's family members, and regional listening sessions.

The commissioner shall provide a report with specific recommendations and timelines for implementation to the legislative committees with jurisdiction over children's mental health policy and finance by November 15, 2018.

Sec. 49. **ENCOUNTER REPORTING OF 340B ELIGIBLE DRUGS.**

(a) The commissioner of human services, in consultation with federally qualified health centers, managed care organizations, and contract pharmacies shall develop a report on the feasibility of a process to identify and report at point of sale the 340B drugs that are dispensed to enrollees of managed care organizations who are patients of a federally qualified health center to exclude these claims from the Medicaid drug rebate program and ensure that duplicate discounts for drugs do not occur.

(b) By January 1, 2018, the commissioner shall present the report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over medical assistance.

Sec. 50. **RATE-SETTING ANALYSIS REPORT.**

The commissioner of human services shall conduct a comprehensive analysis report of the current rate-setting methodology for outpatient, professional, and physician services that do not have a cost-based, federally mandated, or contracted rate. The report shall include recommendations for changes to the existing fee schedule that utilizes the Resource-Based Relative Value System (RBRVS), and alternate payment methodologies for services that do not have relative values, to simplify the fee for service medical assistance rate structure

and to improve consistency and transparency. In developing the report, the commissioner shall consult with outside experts in Medicaid financing. The commissioner shall provide a report on the analysis to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance by November 1, 2019.

Sec. 51. **STUDY OF PAYMENT RATES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES.**

The commissioner of human services shall study the impact of basing medical assistance payment for durable medical equipment and medical supplies on Medicare payment rates, as limited by the payment provisions in the 21st Century Cures Act, Public Law 114-255, on access by medical assistance enrollees to these items. The study must include recommendations for ensuring and improving access by medical assistance enrollees to durable medical equipment and medical supplies. The commissioner shall report study results and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2018.

Sec. 52. **FEDERAL APPROVAL.**

The commissioner of human services shall request any federal waivers and approvals necessary to allow the state to retain federal funds accruing in the state's basic health program trust fund, and expend those funds for purposes other than those specified in Code of Federal Regulations, title 42, part 600.705. The commissioner shall report any federal action regarding this request to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

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

Sec. 53. **FEDERAL WAIVER OR APPROVAL.**

The commissioner of human services shall seek any federal waiver or approval necessary to implement Minnesota Statutes, section 256B.0644.

ARTICLE 2

CONTINUING CARE

Section 1. Minnesota Statutes 2016, section 144.0724, subdivision 6, is amended to read:

Subd. 6. **Penalties for late or nonsubmission.** (a) A facility that fails to complete or submit an assessment according to subdivisions 4 and 5 for a RUG-IV classification within

seven days of the time requirements listed in the Long-Term Care Facility Resident Assessment Instrument User's Manual is subject to a reduced rate for that resident. The reduced rate shall be the lowest rate for that facility. The reduced rate is effective on the day of admission for new admission assessments, on the ARD for significant change in status assessments, or on the day that the assessment was due for all other assessments and continues in effect until the first day of the month following the date of submission and acceptance of the resident's assessment.

(b) If loss of revenue due to penalties incurred by a facility for any period of 92 days are equal to or greater than ~~1.0~~ 0.1 percent of the total operating costs on the facility's most recent annual statistical and cost report, a facility may apply to the commissioner of human services for a reduction in the total penalty amount. The commissioner of human services, in consultation with the commissioner of health, may, at the sole discretion of the commissioner of human services, limit the penalty for residents covered by medical assistance to ~~15~~ ten days.

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

Sec. 2. Minnesota Statutes 2016, section 144.562, subdivision 2, is amended to read:

Subd. 2. **Eligibility for license condition.** (a) A hospital is not eligible to receive a license condition for swing beds unless (1) it either has a licensed bed capacity of less than 50 beds defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66, or it has a licensed bed capacity of 50 beds or more and has swing beds that were approved for Medicare reimbursement before May 1, 1985, or it has a licensed bed capacity of less than 65 beds and the available nursing homes within 50 miles have had, in the aggregate, an average occupancy rate of 96 percent or higher in the most recent two years as documented on the statistical reports to the Department of Health; and (2) it is located in a rural area as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66.

(b) Except for those critical access hospitals established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, eligible hospitals are allowed a total of 2,000 days of swing bed use per year. Critical access hospitals that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, are allowed swing bed use as provided in federal law.

(c) Except for critical access hospitals that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, the commissioner of health may approve swing bed use beyond 2,000 days as long as there are no Medicare certified skilled nursing facility beds available within 25 miles of that hospital that are willing to admit the patient and the patient agrees to the referral being sent to the skilled nursing facility. Critical access hospitals exceeding 2,000 swing bed days must maintain documentation that they have contacted skilled nursing facilities within 25 miles to determine if any skilled nursing facility beds are available that are willing to admit the patient and the patient agrees to the referral being sent to the skilled nursing facility.

(d) After reaching 2,000 days of swing bed use in a year, an eligible hospital to which this limit applies may admit six additional patients to swing beds each year without seeking approval from the commissioner or being in violation of this subdivision. These six swing bed admissions are exempt from the limit of 2,000 annual swing bed days for hospitals subject to this limit.

(e) A health care system that is in full compliance with this subdivision may allocate its total limit of swing bed days among the hospitals within the system, provided that no hospital in the system without an attached nursing home may exceed 2,000 swing bed days per year.

Sec. 3. Minnesota Statutes 2016, section 144A.74, is amended to read:

144A.74 MAXIMUM CHARGES.

A supplemental nursing services agency must not bill or receive payments from a nursing home licensed under this chapter at a rate higher than 150 percent of the sum of the weighted average wage rate, plus a factor determined by the commissioner to incorporate payroll taxes as defined in ~~Minnesota Rules, part 9549.0020, subpart 33~~ section 256R.02, subdivision 37, for the applicable employee classification for the geographic group to which the nursing home is assigned under Minnesota Rules, part 9549.0052. The weighted average wage rates must be determined by the commissioner of human services and reported to the commissioner of health on an annual basis. Wages are defined as hourly rate of pay and shift differential, including weekend shift differential and overtime. Facilities shall provide information necessary to determine weighted average wage rates to the commissioner of human services in a format requested by the commissioner. The maximum rate must include all charges for administrative fees, contract fees, or other special charges in addition to the hourly rates for the temporary nursing pool personnel supplied to a nursing home. A nursing home that pays for the actual travel and housing costs for supplemental nursing services agency staff working

at the facility and that pays these costs to the employee, the agency, or another vendor, is not violating the limitation on charges described in this section.

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

Sec. 4. Minnesota Statutes 2016, section 245D.03, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

excluding providers licensed by the Department of Health under chapter 144A and those providers providing cleaning services only.

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

(1) intervention services, including:

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

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

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

(2) in-home support services, including:

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

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

(iii) semi-independent living services;

(3) residential supports and services, including:

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

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

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

(4) day services, including:

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

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

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

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

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

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

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

Sec. 5. Minnesota Statutes 2016, section 252.27, subdivision 2a, is amended to read:

Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child, including a child determined eligible for medical assistance without consideration of parental income, must contribute to the cost of services used by making monthly payments on a sliding scale based on income, unless the child is married or has been married, parental rights have been terminated, or the child's adoption is subsidized according to chapter 259A or through title IV-E of the Social Security Act. The parental contribution is a partial or full payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating, rehabilitation, maintenance, and personal care services as defined in United States Code, title 26, section 213, needed by the child with a chronic illness or disability.

(b) For households with adjusted gross income equal to or greater than 275 percent of federal poverty guidelines, the parental contribution shall be computed by applying the following schedule of rates to the adjusted gross income of the natural or adoptive parents:

(1) if the adjusted gross income is equal to or greater than 275 percent of federal poverty guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at ~~2.23~~ 1.6725 percent of adjusted gross income at 275

percent of federal poverty guidelines and increases to ~~6.08~~ 4.56 percent of adjusted gross income for those with adjusted gross income up to 545 percent of federal poverty guidelines;

(2) if the adjusted gross income is greater than 545 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be ~~6.08~~ 4.56 percent of adjusted gross income;

(3) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 975 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at ~~6.08~~ 4.56 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to ~~8.1~~ 6.075 percent of adjusted gross income for those with adjusted gross income up to 975 percent of federal poverty guidelines; and

(4) if the adjusted gross income is equal to or greater than 975 percent of federal poverty guidelines, the parental contribution shall be ~~10.13~~ 7.5975 percent of adjusted gross income.

If the child lives with the parent, the annual adjusted gross income is reduced by $2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents, including the child receiving services. Adjustments in the contribution amount due to annual changes in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

(d) For purposes of paragraph (b), "income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form, except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds have been used to purchase a home shall not be counted as income.

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a

reduction in or waiver of parental fees until the excess amount is exhausted. All reimbursements must include a notice that the amount reimbursed may be taxable income if the parent paid for the parent's fees through an employer's health care flexible spending account under the Internal Revenue Code, section 125, and that the parent is responsible for paying the taxes owed on the amount reimbursed.

(f) The monthly contribution amount must be reviewed at least every 12 months; when there is a change in household size; and when there is a loss of or gain in income from one month to another in excess of ten percent. The local agency shall mail a written notice 30 days in advance of the effective date of a change in the contribution amount. A decrease in the contribution amount is effective in the month that the parent verifies a reduction in income or change in household size.

(g) Parents of a minor child who do not live with each other shall each pay the contribution required under paragraph (a). An amount equal to the annual court-ordered child support payment actually paid on behalf of the child receiving services shall be deducted from the adjusted gross income of the parent making the payment prior to calculating the parental contribution under paragraph (b).

(h) The contribution under paragraph (b) shall be increased by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child. For purposes of this section, "available" means the insurance is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income. For purposes of this section, "insurance" means health and accident insurance coverage, enrollment in a nonprofit health service plan, health maintenance organization, self-insured plan, or preferred provider organization.

Parents who have more than one child receiving services shall not be required to pay more than the amount for the child with the highest expenditures. There shall be no resource contribution from the parents. The parent shall not be required to pay a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

(i) The contribution under paragraph (b) shall be reduced by $300 per fiscal year if, in the 12 months prior to July 1:

(1) the parent applied for insurance for the child;

(2) the insurer denied insurance;

(3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a complaint or appeal, in writing, to the commissioner of health or the commissioner of commerce, or litigated the complaint or appeal; and

(4) as a result of the dispute, the insurer reversed its decision and granted insurance.

For purposes of this section, "insurance" has the meaning given in paragraph (h).

A parent who has requested a reduction in the contribution amount under this paragraph shall submit proof in the form and manner prescribed by the commissioner or county agency, including, but not limited to, the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14.

Sec. 6. Minnesota Statutes 2016, section 252.41, subdivision 3, is amended to read:

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

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

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

(b) Day training and habilitation services reimbursable under this section do not include special education and related services as defined in the Education of the Individuals with Disabilities Act, United States Code, title 20, chapter 33, section 1401, clauses (6) and (17), or vocational services funded under section 110 of the Rehabilitation Act of 1973, United States Code, title 29, section 720, as amended.

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

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

Sec. 7. **[256.9755] CAREGIVER SUPPORT PROGRAMS.**

Subdivision 1. **Program goals.** It is the goal of all area agencies on aging and caregiver support programs to support family caregivers of persons with Alzheimer's disease or other related dementias who are living in the community by:

(1) promoting caregiver support programs that serve Minnesotans in their homes and communities; and

(2) providing, within the limits of available funds, the caregiver support services that will enable the family caregiver to access caregiver support programs in the most cost-effective and efficient manner.

Subd. 2. **Authority.** The Minnesota Board on Aging shall allocate to area agencies on aging the state and federal funds which are received for the caregiver support program in a manner consistent with federal requirements.

Subd. 3. **Caregiver support services.** Funds allocated to an area agency on aging for caregiver support services must be used in a manner consistent with the National Family Caregiver Support Program to reach family caregivers of persons with Alzheimer's disease or related dementias. The funds must be used to provide social, nonmedical, community-based services and activities that provide respite for caregivers and social interaction for participants.

Sec. 8. Minnesota Statutes 2016, section 256B.0625, subdivision 6a, is amended to read:

Subd. 6a. **Home health services.** Home health services are those services specified in Minnesota Rules, part 9505.0295 and sections 256B.0651 and 256B.0653. Medical assistance covers home health services at a recipient's home residence or in the community where normal life activities take the recipient. Medical assistance does not cover home health services for residents of a hospital, nursing facility, or intermediate care facility, unless the commissioner of human services has authorized skilled nurse visits for less than 90 days for a resident at an intermediate care facility for persons with developmental disabilities, to prevent an admission to a hospital or nursing facility or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the home health services or forgoes the facility per diem for the leave days that home health services are used. Home health services must be provided by a Medicare certified home health agency. All nursing

and home health aide services must be provided according to sections 256B.0651 to 256B.0653.

Sec. 9. Minnesota Statutes 2016, section 256B.0653, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For the purposes of this section, the following terms have the meanings given.

(a) "Assessment" means an evaluation of the recipient's medical need for home health agency services by a registered nurse or appropriate therapist that is conducted within 30 days of a request.

(b) "Home care therapies" means occupational, physical, and respiratory therapy and speech-language pathology services provided in the home by a Medicare certified home health agency.

(c) "Home health agency services" means services delivered ~~in the recipient's home residence, except as specified in section 256B.0625,~~ by a home health agency to a recipient with medical needs due to illness, disability, or physical conditions in settings permitted under section 256B.0625, subdivision 6a.

(d) "Home health aide" means an employee of a home health agency who completes medically oriented tasks written in the plan of care for a recipient.

(e) "Home health agency" means a home care provider agency that is Medicare-certified.

(f) "Occupational therapy services" mean the services defined in Minnesota Rules, part 9505.0390.

(g) "Physical therapy services" mean the services defined in Minnesota Rules, part 9505.0390.

(h) "Respiratory therapy services" mean the services defined in chapter 147C.

(i) "Speech-language pathology services" mean the services defined in Minnesota Rules, part 9505.0390.

(j) "Skilled nurse visit" means a professional nursing visit to complete nursing tasks required due to a recipient's medical condition that can only be safely provided by a professional nurse to restore and maintain optimal health.

(k) "Store-and-forward technology" means telehomecare services that do not occur in real time via synchronous transmissions such as diabetic and vital sign monitoring.

(l) "Telehomecare" means the use of telecommunications technology via live, two-way interactive audiovisual technology which may be augmented by store-and-forward technology.

(m) "Telehomecare skilled nurse visit" means a visit by a professional nurse to deliver a skilled nurse visit to a recipient located at a site other than the site where the nurse is located and is used in combination with face-to-face skilled nurse visits to adequately meet the recipient's needs.

Sec. 10. Minnesota Statutes 2016, section 256B.0653, subdivision 3, is amended to read:

Subd. 3. **Home health aide visits.** (a) Home health aide visits must be provided by a certified home health aide using a written plan of care that is updated in compliance with Medicare regulations. A home health aide shall provide hands-on personal care, perform simple procedures as an extension of therapy or nursing services, and assist in instrumental activities of daily living as defined in section 256B.0659, including assuring that the person gets to medical appointments if identified in the written plan of care. Home health aide visits ~~must~~ may be provided in the recipient's home or in the community where normal life activities take the recipient.

(b) All home health aide visits must have authorization under section 256B.0652. The commissioner shall limit home health aide visits to no more than one visit per day per recipient.

(c) Home health aides must be supervised by a registered nurse or an appropriate therapist when providing services that are an extension of therapy.

Sec. 11. Minnesota Statutes 2016, section 256B.0653, subdivision 4, is amended to read:

Subd. 4. **Skilled nurse visit services.** (a) Skilled nurse visit services must be provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse, according to the written plan of care and accepted standards of medical and nursing practice according to chapter 148. Skilled nurse visit services must be ordered by a physician and documented in a plan of care that is reviewed and approved by the ordering physician at least once every 60 days. All skilled nurse visits must be medically necessary and provided in the recipient's home residence or in the community where normal life activities take the recipient, except as allowed under section 256B.0625, subdivision 6a.

(b) Skilled nurse visits include face-to-face and telehomecare visits with a limit of up to two visits per day per recipient. All visits must be based on assessed needs.

(c) Telehomecare skilled nurse visits are allowed when the recipient's health status can be accurately measured and assessed without a need for a face-to-face, hands-on encounter. All telehomecare skilled nurse visits must have authorization and are paid at the same allowable rates as face-to-face skilled nurse visits.

(d) The provision of telehomecare must be made via live, two-way interactive audiovisual technology and may be augmented by utilizing store-and-forward technologies. Individually identifiable patient data obtained through real-time or store-and-forward technology must be maintained as health records according to sections 144.291 to 144.298. If the video is used for research, training, or other purposes unrelated to the care of the patient, the identity of the patient must be concealed.

(e) Authorization for skilled nurse visits must be completed under section 256B.0652. A total of nine face-to-face skilled nurse visits per calendar year do not require authorization. All telehomecare skilled nurse visits require authorization.

Sec. 12. Minnesota Statutes 2016, section 256B.0653, subdivision 5, is amended to read:

Subd. 5. **Home care therapies.** (a) Home care therapies include the following: physical therapy, occupational therapy, respiratory therapy, and speech and language pathology therapy services.

(b) Home care therapies must be:

(1) provided in the recipient's residence or in the community where normal life activities take the recipient after it has been determined the recipient is unable to access outpatient therapy;

(2) prescribed, ordered, or referred by a physician and documented in a plan of care and reviewed, according to Minnesota Rules, part 9505.0390;

(3) assessed by an appropriate therapist; and

(4) provided by a Medicare-certified home health agency enrolled as a Medicaid provider agency.

(c) Restorative and specialized maintenance therapies must be provided according to Minnesota Rules, part 9505.0390. Physical and occupational therapy assistants may be used as allowed under Minnesota Rules, part 9505.0390, subpart 1, item B.

(d) For both physical and occupational therapies, the therapist and the therapist's assistant may not both bill for services provided to a recipient on the same day.

Sec. 13. Minnesota Statutes 2016, section 256B.0653, subdivision 6, is amended to read:

Subd. 6. **Noncovered home health agency services.** The following are not eligible for payment under medical assistance as a home health agency service:

(1) telehomecare skilled nurses services that is communication between the home care nurse and recipient that consists solely of a telephone conversation, facsimile, electronic mail, or a consultation between two health care practitioners;

(2) the following skilled nurse visits:

(i) for the purpose of monitoring medication compliance with an established medication program for a recipient;

(ii) administering or assisting with medication administration, including injections, prefilling syringes for injections, or oral medication setup of an adult recipient, when, as determined and documented by the registered nurse, the need can be met by an available pharmacy or the recipient or a family member is physically and mentally able to self-administer or prefill a medication;

(iii) services done for the sole purpose of supervision of the home health aide or personal care assistant;

(iv) services done for the sole purpose to train other home health agency workers;

(v) services done for the sole purpose of blood samples or lab draw when the recipient is able to access these services outside the home; and

(vi) Medicare evaluation or administrative nursing visits required by Medicare;

(3) home health aide visits when the following activities are the sole purpose for the visit: companionship, socialization, household tasks, transportation, and education; ~~and~~

(4) home care therapies provided in other settings such as a clinic~~, day program,~~ or as an inpatient or when the recipient can access therapy outside of the recipient's residence; and

(5) home health agency services without qualifying documentation of a face-to-face encounter as specified in subdivision 7.

Sec. 14. Minnesota Statutes 2016, section 256B.0653, is amended by adding a subdivision to read:

Subd. 7. **Face-to-face encounter.** (a) A face-to-face encounter by a qualifying provider must be completed for all home health services regardless of the need for prior authorization,

except when providing a onetime perinatal visit by skilled nursing. The face-to-face encounter may occur through telemedicine as defined in section 256B.0625, subdivision 3b. The encounter must be related to the primary reason the recipient requires home health services and must occur within the 90 days before or the 30 days after the start of services. The face-to-face encounter may be conducted by one of the following practitioners, licensed in Minnesota:

(1) a physician;

(2) a nurse practitioner or clinical nurse specialist;

(3) a certified nurse midwife; or

(4) a physician assistant.

(b) The allowed nonphysician practitioner, as described in this subdivision, performing the face-to-face encounter must communicate the clinical findings of that face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the recipient's medical record. To assure clinical correlation between the face-to-face encounter and the associated home health services, the physician responsible for ordering the services must:

(1) document that the face-to-face encounter, which is related to the primary reason the recipient requires home health services, occurred within the required time period; and

(2) indicate the practitioner who conducted the encounter and the date of the encounter.

(c) For home health services requiring authorization, including prior authorization, home health agencies must retain the qualifying documentation of a face-to-face encounter as part of the recipient health service record, and submit the qualifying documentation to the commissioner or the commissioner's designee upon request.

Sec. 15. Minnesota Statutes 2016, section 256B.431, subdivision 30, is amended to read:

Subd. 30. **Bed layaway and delicensure.** (a) For rate years beginning on or after July 1, 2000, a nursing facility reimbursed under this section which has placed beds on layaway shall, for purposes of application of the downsizing incentive in subdivision 3a, paragraph (c), and calculation of the rental per diem, have those beds given the same effect as if the beds had been delicensed so long as the beds remain on layaway. At the time of a layaway, a facility may change its single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11. The property payment rate increase shall be effective the first day of the month of January or July, whichever occurs first following the

~~month~~ date in which the layaway of the beds becomes effective under section 144A.071, subdivision 4b.

(b) For rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434, a nursing facility reimbursed under that section which has placed beds on layaway shall, for so long as the beds remain on layaway, be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) retain or change the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and

(3) establish capacity days based on the number of beds immediately prior to the layaway and the number of beds after the layaway.

The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the layaway of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4, paragraph (c). The property payment rate increase shall be effective the first day of the month of January or July, whichever occurs first following the ~~month~~ date in which the layaway of the beds becomes effective.

(c) If a nursing facility removes a bed from layaway status in accordance with section 144A.071, subdivision 4b, the commissioner shall establish capacity days based on the number of licensed and certified beds in the facility not on layaway and shall reduce the nursing facility's property payment rate in accordance with paragraph (b).

(d) For the rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434, a nursing facility reimbursed under that section, which has delicensed beds after July 1, 2000, by giving notice of the delicensure to the commissioner of health according to the notice requirements in section 144A.071, subdivision 4b, shall be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) retain or change the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and

(3) establish capacity days based on the number of beds immediately prior to the delicensure and the number of beds after the delicensure.

The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the delicensure of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4, paragraph (c). The property payment rate increase shall be effective the first day of the month of January or July, whichever occurs first following the ~~month~~ date in which the delicensure of the beds becomes effective.

(e) For nursing facilities reimbursed under this section or section 256B.434, any beds placed on layaway shall not be included in calculating facility occupancy as it pertains to leave days defined in Minnesota Rules, part 9505.0415.

(f) For nursing facilities reimbursed under this section or section 256B.434, the rental rate calculated after placing beds on layaway may not be less than the rental rate prior to placing beds on layaway.

(g) A nursing facility receiving a rate adjustment as a result of this section shall comply with section ~~256B.47~~ 256R.06, subdivision ~~2~~ 5.

(h) A facility that does not utilize the space made available as a result of bed layaway or delicensure under this subdivision to reduce the number of beds per room or provide more common space for nursing facility uses or perform other activities related to the operation of the nursing facility shall have its property rate increase calculated under this subdivision reduced by the ratio of the square footage made available that is not used for these purposes to the total square footage made available as a result of bed layaway or delicensure.

Sec. 16. Minnesota Statutes 2016, section 256B.434, subdivision 4, is amended to read:

Subd. 4. **Alternate rates for nursing facilities.** Effective for the rate years beginning on and after January 1, 2018, a nursing facility's ~~case mix~~ property payment ~~rates~~ rate for the second and subsequent years of a facility's contract under this section are the previous rate year's ~~contract~~ property payment ~~rates~~ rate plus an inflation adjustment ~~and, for facilities~~

~~reimbursed under this section or section 256B.431, an adjustment to include the cost of any increase in Health Department licensing fees for the facility taking effect on or after July 1, 2001~~. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the ~~commissioner of management and budget's national economic consultant~~ Reports and Forecasts Division of the Department of Human Services, as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. ~~For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, this paragraph shall apply only to the property-related payment rate. For the rate years beginning on October 1, 2011, October 1, 2012, October 1, 2013, October 1, 2014, October 1, 2015, January 1, 2016, and January 1, 2017, the rate adjustment under this paragraph shall be suspended. Beginning in 2005, adjustment to the property payment rate under this section and section 256B.431 shall be effective on October 1. In determining the amount of the property-related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property-related based on the facility's most recent cost report.~~

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

Sec. 17. Minnesota Statutes 2016, section 256B.4913, subdivision 4a, is amended to read:

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

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

(1) for a day service recipient who was not authorized to receive these waiver services prior to January 1, 2014; added a new service or services on or after January 1, 2014; or changed providers on or after January 1, 2014, the historical rate must be the weighted

average authorized rate for the provider number in the county of service, effective December 1, 2013; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 19. Minnesota Statutes 2016, section 256B.4914, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

(l) "Shared staffing" means time spent by employees, not defined under paragraph (f), providing or available to provide more than one individual with direct support and assistance with activities of daily living as defined under section 256B.0659, subdivision 1, paragraph (b); instrumental activities of daily living as defined under section 256B.0659, subdivision 1, paragraph (i); ancillary activities needed to support individual services; and training to participants, and is based on the requirements in each individual's coordinated service and support plan under section 245D.02, subdivision 4b; any coordinated service and support

plan addendum under section 245D.02, subdivision 4c; an assessment tool; and provider observation of an individual's service need. Total shared staffing hours are divided proportionally by the number of individuals who receive the shared service provisions.

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

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

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

(2) for day services under subdivision 7:

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 20. Minnesota Statutes 2016, section 256B.4914, subdivision 3, is amended to read:

Subd. 3. **Applicable services.** Applicable services are those authorized under the state's home and community-based services waivers under sections 256B.092 and 256B.49, including the following, as defined in the federally approved home and community-based services plan:

(1) 24-hour customized living;

(2) adult day care;

(3) adult day care bath;

(4) behavioral programming;

(5) companion services;

(6) customized living;

(7) day training and habilitation;

(8) housing access coordination;

(9) independent living skills;

(10) in-home family support;

(11) night supervision;

(12) personal support;

(13) prevocational services;

(14) residential care services;

(15) residential support services;

(16) respite services;

(17) structured day services;

~~(18) supported employment services;~~

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

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

(20) independent living skills specialist services;

(21) employment exploration services;

(22) employment development services;

(23) employment support services; and

~~(21)~~ (24) other services as approved by the federal government in the state home and community-based services plan.

EFFECTIVE DATE. This section is effective upon federal approval, except clause (20) is effective January 1, 2020. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 21. Minnesota Statutes 2016, section 256B.4914, subdivision 5, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(11)~~ (12) for ~~supported~~ employment supports services staff, ~~20~~ 50 percent of the median wage for ~~nursing aide~~ rehabilitation counselor (SOC code ~~31-1012~~ 21-1015); ~~20 percent of~~

~~the median wage for psychiatric technician (SOC code 29-2053);~~ and ~~60~~ 50 percent of the median wage for community and social ~~and human~~ services ~~aide~~ specialist (SOC code ~~21-1093~~ 21-1099);

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

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

~~(12)~~ (15) for adult companion staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing ~~aides, orderlies, and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

~~(13)~~ (16) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing ~~aide~~ assistant (SOC code ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

~~(14)~~ (17) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing ~~aides, orderlies, and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

~~(15)~~ (18) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing ~~aides, orderlies, and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

~~(16)~~ (19) for supervisory staff, the basic wage is $17.43 per hour with exception of the supervisor of behavior analyst and behavior specialists, which must be $30.75 per hour;

~~(17)~~ (20) for registered nurse, the basic wage is $30.82 per hour; and

~~(18)~~ (21) for licensed practical nurse staff, ~~the basic wage is $18.64 per hour~~ 100 percent of the median wage for licensed practical nurses (SOC code 29-2061).

(b) Component values for residential support services are:

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

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

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

(4) general administrative support ratio: 13.25 percent;

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

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

(c) Component values for family foster care are:

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

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

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

(4) general administrative support ratio: 3.3 percent;

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

(6) absence factor: 1.7 percent.

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

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

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

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

(4) program plan support ratio: 5.6 percent;

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

(6) general administrative support ratio: 13.25 percent;

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

(8) absence and utilization factor ratio: ~~3.9~~ 5.9 percent.

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

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

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

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

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

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

(6) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

(6) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

(4) general administrative support ratio: 13.25 percent;

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

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

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

(i) On July 1, 2017, the commissioner shall update the framework components in ~~paragraphs (b) to (g)~~ paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f),

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

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

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

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

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

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

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

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

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

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

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

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

EFFECTIVE DATE. (a) The amendments to paragraphs (a) to (g) are effective January 1, 2018, except paragraph (d), clause (8), is effective January 1, 2019.

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

Sec. 22. Minnesota Statutes 2016, section 256B.4914, subdivision 6, is amended to read:

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

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

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

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

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

(5) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the product of the supervision span of control ratio in subdivision 5, paragraph (b), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (19);

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 23. Minnesota Statutes 2016, section 256B.4914, subdivision 7, is amended to read:

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

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

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

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

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

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

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

(5) multiply the number of day direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (d), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (19);

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

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

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

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

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

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

(12) this is the subtotal rate;

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 24. Minnesota Statutes 2016, section 256B.4914, subdivision 8, is amended to read:

Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based services with programming, including behavior programming, housing access coordination, in-home family support, independent living skills training, independent living skills specialist services, hourly supported living services, employment exploration services, employment development services, and ~~supported~~ employment support services provided to an individual outside of any day or residential service plan must be calculated as follows, unless the services are authorized separately under subdivision 6 or 7:

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

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

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

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

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (19);

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

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

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

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

(10) this is the subtotal rate;

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

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

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

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

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

Sec. 25. Minnesota Statutes 2016, section 256B.4914, subdivision 9, is amended to read:

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

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

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

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

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

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (19);

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

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

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

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

(10) this is the subtotal rate;

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

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

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

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

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

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

(17) multiply the number of direct staff hours by the product of the supervisory span of control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (19);

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

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

(20) this is the subtotal rate;

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

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

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

Sec. 26. Minnesota Statutes 2016, section 256B.4914, subdivision 10, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) service utilization;

(3) county and tribal allocation changes; and

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

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

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

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

(i) The commissioner shall study the underlying cost of absence and utilization for day services. Based on the commissioner's evaluation of the data collected under this paragraph, the commissioner shall make recommendations to the legislature by January 15, 2018, for changes, if any, to the absence and utilization factor ratio component value for day services.

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

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

Sec. 27. Minnesota Statutes 2016, section 256B.50, subdivision 1b, is amended to read:

Subd. 1b. **Filing an appeal.** To appeal, the provider shall file with the commissioner a written notice of appeal; the appeal must be postmarked or received by the commissioner

within 60 days of the publication date ~~the determination of the payment rate was mailed or personally received by a provider, whichever is earlier~~ printed on the rate notice. The notice of appeal must specify each disputed item; the reason for the dispute; the total dollar amount in dispute for each separate disallowance, allocation, or adjustment of each cost item or part of a cost item; the computation that the provider believes is correct; the authority in statute or rule upon which the provider relies for each disputed item; the name and address of the person or firm with whom contacts may be made regarding the appeal; and other information required by the commissioner.

Sec. 28. Minnesota Statutes 2016, section 256B.5012, is amended by adding a subdivision to read:

Subd. 3a. **Therapeutic leave days.** Notwithstanding Minnesota Rules, part 9505.0415, subpart 7, a vacant bed in an intermediate care facility for persons with developmental disabilities shall be counted as a reserved bed when determining occupancy rates and eligibility for payment of a therapeutic leave day.

Sec. 29. Minnesota Statutes 2016, section 256B.5012, is amended by adding a subdivision to read:

Subd. 17. **ICF/DD rate increase effective July 1, 2017; Murray County.** Effective July 1, 2017, the daily rate for an intermediate care facility for persons with developmental disabilities located in Murray County that is classified as a class B facility and licensed for 14 beds is $400. This increase is in addition to any other increase that is effective on July 1, 2017.

Sec. 30. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision to read:

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

Sec. 31. Minnesota Statutes 2016, section 256C.23, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

Sec. 34. Minnesota Statutes 2016, section 256C.233, subdivision 1, is amended to read:

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

~~Hard-of-Hearing Services Division.~~ The commissioner of human services shall coordinate the work of the interagency ~~management team~~ advisers and receive legislative appropriations for the division.

Sec. 35. Minnesota Statutes 2016, section 256C.233, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

(ii) otherwise need culturally affirmative therapeutic services;

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 36. Minnesota Statutes 2016, section 256C.24, subdivision 1, is amended to read:

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

Sec. 37. Minnesota Statutes 2016, section 256C.24, subdivision 2, is amended to read:

Subd. 2. **Responsibilities.** (a) Each regional service center shall:

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

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

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

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

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

~~(4) implement a plan to provide loaned equipment and resource materials to deaf, deafblind, and hard-of-hearing~~ (6) have a mobile or permanent lab where persons who are

deaf, persons who are deafblind, and persons who are hard-of-hearing can try a selection of modern assistive technology and equipment to determine what would best meet the persons' needs;

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

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

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

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

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

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

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

(ii) otherwise need culturally affirmative therapeutic services; and

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

(b) Persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing, and the persons' family members who travel more than 50 miles round-trip

from the persons' home or work location to receive services at the regional service center may be reimbursed for mileage at the reimbursement rate established by the Internal Revenue Service.

Sec. 38. Minnesota Statutes 2016, section 256C.261, is amended to read:

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

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

The commissioner shall award grants for the purposes of:

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

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

(b) The commissioner may make grants:

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

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

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

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

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

Sec. 39. Minnesota Statutes 2016, section 256R.02, subdivision 4, is amended to read:

Subd. 4. **Administrative costs.** "Administrative costs" means the identifiable costs for administering the overall activities of the nursing home. These costs include salaries and wages of the administrator, assistant administrator, business office employees, security guards, and associated fringe benefits and payroll taxes, fees, contracts, or purchases related to business office functions, licenses, and permits except as provided in the external fixed costs category, employee recognition, travel including meals and lodging, all training except as specified in subdivision 17, voice and data communication or transmission, office supplies, property and liability insurance and other forms of insurance not ~~designated to other areas~~ including insurance that is an employee benefit, personnel recruitment, legal services, accounting services, management or business consultants, data processing, information technology, Web site, central or home office costs, business meetings and seminars, postage, fees for professional organizations, subscriptions, security services, advertising, board of directors fees, working capital interest expense, ~~and~~ bad debts and bad debt collection fees, and costs incurred for travel and housing for persons employed by a supplemental nursing services agency as defined in section 144A.70, subdivision 6.

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

Sec. 40. Minnesota Statutes 2016, section 256R.02, subdivision 17, is amended to read:

Subd. 17. **Direct care costs.** "Direct care costs" means costs for the wages of nursing administration, direct care registered nurses, licensed practical nurses, certified nursing assistants, trained medication aides, employees conducting training in resident care topics and associated fringe benefits and payroll taxes; services from a supplemental nursing services agency; supplies that are stocked at nursing stations or on the floor and distributed or used individually, including, but not limited to: alcohol, applicators, cotton balls, incontinence pads, disposable ice bags, dressings, bandages, water pitchers, tongue depressors, disposable gloves, enemas, enema equipment, soap, medication cups, diapers, plastic waste bags, sanitary products, thermometers, hypodermic needles and syringes, clinical reagents or similar diagnostic agents, drugs that are not paid on a separate fee schedule by the medical assistance program or any other payer, and technology related to the provision of nursing care to residents, such as electronic charting systems; costs of materials used for resident care training, and training courses outside of the facility attended by direct care staff on resident care topics; and costs for nurse consultants, pharmacy consultants, and medical directors. Salaries and payroll taxes for nurse consultants who

work out of a central office must be allocated proportionately by total resident days or by direct identification to the nursing facilities served by those consultants.

Sec. 41. Minnesota Statutes 2016, section 256R.02, subdivision 18, is amended to read:

Subd. 18. **Employer health insurance costs.** "Employer health insurance costs" means premium expenses for group coverage ~~and reinsurance~~, actual expenses incurred for self-insured plans including reinsurance and administrative costs, and employer contributions to employee health reimbursement and health savings accounts. Premium and expense costs and contributions are allowable for (1) all employees and (2) the spouse and dependents of those employees who ~~meet the definition of full-time employees under the federal Affordable Care Act, Public Law 111-148~~ are employed on average at least 30 hours of service per week, or 130 hours of service per month.

Sec. 42. Minnesota Statutes 2016, section 256R.02, subdivision 19, is amended to read:

Subd. 19. **External fixed costs.** "External fixed costs" means costs related to the nursing home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122; family advisory council fee under section 144A.33; scholarships under section 256R.37; planned closure rate adjustments under section 256R.40; consolidation rate adjustments under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d; single-bed room incentives under section 256R.41; property taxes, assessments, and payments in lieu of taxes; employer health insurance costs; quality improvement incentive payment rate adjustments under section 256R.39; performance-based incentive payments under section 256R.38; special dietary needs under section 256R.51; rate adjustments for compensation-related costs for minimum wage changes under section 256R.49 provided on or after January 1, 2018; and Public Employees Retirement Association employer costs.

Sec. 43. Minnesota Statutes 2016, section 256R.02, subdivision 22, is amended to read:

Subd. 22. **Fringe benefit costs.** "Fringe benefit costs" means the costs for group life, dental, workers' compensation, ~~and other employee insurances and~~ short- and long-term disability, long-term care insurance, accident insurance, supplemental insurance, legal assistance insurance, profit sharing, health insurance costs not covered under subdivision 18, including costs associated with part-time employee family members or retirees, and pension and retirement plan contributions, except for the Public Employees Retirement Association ~~and employer health insurance costs; profit sharing; and retirement plans for which the employer pays all or a portion of the~~ costs.

Sec. 44. Minnesota Statutes 2016, section 256R.02, subdivision 42, is amended to read:

Subd. 42. **Raw food costs.** "Raw food costs" means the cost of food provided to nursing facility residents and the allocation of dietary credits. Also included are special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet.

Sec. 45. Minnesota Statutes 2016, section 256R.02, is amended by adding a subdivision to read:

Subd. 42a. **Real estate taxes.** "Real estate taxes" means the real estate tax liability shown on the annual property tax statement of the nursing facility for the reporting period. The term does not include personnel costs or fees for late payment.

Sec. 46. Minnesota Statutes 2016, section 256R.02, is amended by adding a subdivision to read:

Subd. 48a. **Special assessments.** "Special assessments" means the actual special assessments and related interest paid during the reporting period. The term does not include personnel costs or fees for late payment.

Sec. 47. Minnesota Statutes 2016, section 256R.02, subdivision 52, is amended to read:

Subd. 52. **Therapy costs.** "Therapy costs" means any costs related to ~~medical assistance~~ therapy services provided to residents that are not ~~billed~~ separately billable from the daily operating rate.

Sec. 48. Minnesota Statutes 2016, section 256R.06, subdivision 5, is amended to read:

Subd. 5. **Notice to residents.** (a) No increase in nursing facility rates for private paying residents shall be effective unless the nursing facility notifies the resident or person responsible for payment of the increase in writing 30 days before the increase takes effect. The notice must include the amount of the rate increase, the new payment rate, and the date the rate increase takes effect.

A nursing facility may adjust its rates without giving the notice required by this subdivision when the purpose of the rate adjustment is to reflect a change in the case mix classification of the resident. The nursing facility shall notify private pay residents of any rate increase related to a change in case mix classifications in a timely manner after confirmation of the case mix classification change is received from the Department of Health.

If the state fails to set rates as required by section 256R.09, subdivision 1, the time required for giving notice is decreased by the number of days by which the state was late in setting the rates.

(b) If the state does not set rates by the date required in section 256R.09, subdivision 1, or otherwise provides nursing facilities with retroactive notification of the amount of a rate increase, nursing facilities shall meet the requirement for advance notice by informing the resident or person responsible for payments, on or before the effective date of the increase, that a rate increase will be effective on that date. The requirements of paragraph (a) do not apply to situations described in this paragraph.

If the exact amount has not yet been determined, the nursing facility may raise the rates by the amount anticipated to be allowed. Any amounts collected from private pay residents in excess of the allowable rate must be repaid to private pay residents with interest at the rate used by the commissioner of revenue for the late payment of taxes and in effect on the date the rate increase is effective.

Sec. 49. Minnesota Statutes 2016, section 256R.07, subdivision 1, is amended to read:

Subdivision 1. **Criteria.** A nursing facility shall keep adequate documentation. In order to be adequate, documentation must:

(1) be maintained in orderly, well-organized files;

(2) not include documentation of more than one nursing facility in one set of files unless transactions may be traced by the commissioner to the nursing facility's annual cost report;

(3) include a paid invoice or copy of a paid invoice with date of purchase, vendor name and address, purchaser name and delivery destination address, listing of items or services purchased, cost of items purchased, account number to which the cost is posted, and a breakdown of any allocation of costs between accounts or nursing facilities. If any of the information is not available, the nursing facility shall document its good faith attempt to obtain the information;

(4) include contracts, agreements, amortization schedules, mortgages, other debt instruments, and all other documents necessary to explain the nursing facility's costs or revenues; and

(5) be retained by the nursing facility to support the five most recent annual cost reports. The commissioner may extend the period of retention if the field audit was postponed because of inadequate record keeping or accounting practices as in section 256R.13, subdivisions 2 and 4, the records are necessary to resolve a pending appeal, or the records

are required for the enforcement of sections 256R.04; 256R.05, subdivision 2; 256R.06, subdivisions 2~~,~~ and 6~~, and 7~~; 256R.08, subdivisions 1 to 3; and 256R.09, subdivisions 3 and 4.

Sec. 50. Minnesota Statutes 2016, section 256R.07, is amended by adding a subdivision to read:

Subd. 6. **Electronic signature.** For documentation requiring a signature under this chapter or section 256B.431 or 256B.434, use of an electronic signature as defined under section 325L.02, paragraph (h), is allowed.

Sec. 51. Minnesota Statutes 2016, section 256R.13, subdivision 4, is amended to read:

Subd. 4. **Extended record retention requirements.** The commissioner shall extend the period for retention of records under section 256R.09, subdivision 3, for purposes of performing field audits as necessary to enforce sections 256R.04; 256R.05, subdivision 2; 256R.06, subdivisions 2~~,~~ and 6~~, and 7~~; 256R.08, subdivisions 1 to 3; and 256R.09, subdivisions 3 and 4, with written notice to the facility postmarked no later than 90 days prior to the expiration of the record retention requirement.

Sec. 52. **[256R.18] BIENNIAL REPORT.**

The commissioner shall provide to the legislative committees with jurisdiction over nursing facility payment rates a biennial report including:

(1) the impact of using cost report data to set rates without updating the cost report data by the change in the Consumer Price Index for all urban consumers from the mid-point of the cost report to the mid-point of the rate year;

(2) the impact of the quality adjusted care limits;

(3) the ability of nursing facilities to retain employees, including whether rate increases are passed through to employees;

(4) the efficacy of the critical access nursing facility program under section 256R.47; and

(5) the impact of payment rate limit reduction under section 256R.23, subdivision 6.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 53. Minnesota Statutes 2016, section 256R.37, is amended to read:

256R.37 SCHOLARSHIPS.

(a) For the 27-month period beginning October 1, 2015, through December 31, 2017, the commissioner shall allow a scholarship per diem of up to 25 cents for each nursing facility with no scholarship per diem that is requesting a scholarship per diem to be added to the external fixed payment rate to be used:

(1) for employee scholarships that satisfy the following requirements:

(i) scholarships are available to all employees who work an average of at least ten hours per week at the facility except the administrator, and to reimburse student loan expenses for ~~newly hired and recently graduated~~ registered nurses and licensed practical nurses, and training expenses for nursing assistants as specified in section 144A.611, subdivisions 2 and 4~~, who are newly hired and have graduated within the last 12 months~~; and

(ii) the course of study is expected to lead to career advancement with the facility or in long-term care, including medical care interpreter services and social work; and

(2) to provide job-related training in English as a second language.

(b) All facilities may annually request a rate adjustment under this section by submitting information to the commissioner on a schedule and in a form supplied by the commissioner. The commissioner shall allow a scholarship payment rate equal to the reported and allowable costs divided by resident days.

(c) In calculating the per diem under paragraph (b), the commissioner shall allow costs related to tuition, direct educational expenses, and reasonable costs as defined by the commissioner for child care costs and transportation expenses related to direct educational expenses.

(d) The rate increase under this section is an optional rate add-on that the facility must request from the commissioner in a manner prescribed by the commissioner. The rate increase must be used for scholarships as specified in this section.

(e) For instances in which a rate adjustment will be 15 cents or greater, nursing facilities that close beds during a rate year may request to have their scholarship adjustment under paragraph (b) recalculated by the commissioner for the remainder of the rate year to reflect the reduction in resident days compared to the cost report year.

Sec. 54. Minnesota Statutes 2016, section 256R.40, subdivision 1, is amended to read:

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

(b) "Closure" means the cessation of operations of a nursing facility and delicensure and decertification of all beds within the facility.

(c) "Closure plan" means a plan to close a nursing facility and reallocate a portion of the resulting savings to provide planned closure rate adjustments at other facilities.

(d) "Commencement of closure" means the date on which residents and designated representatives are notified of a planned closure as provided in section 144A.161, subdivision 5a, as part of an approved closure plan.

(e) "Completion of closure" means the date on which the final resident of the nursing facility designated for closure in an approved closure plan is discharged from the facility or the date that beds from a partial closure are delicensed and decertified.

(f) "Partial closure" means the delicensure and decertification of a portion of the beds within the facility.

(g) "Planned closure rate adjustment" means an increase in a nursing facility's operating rates resulting from a planned closure or a planned partial closure of another facility.

Sec. 55. Minnesota Statutes 2016, section 256R.40, subdivision 5, is amended to read:

Subd. 5. **Planned closure rate adjustment.** (a) The commissioner shall calculate the amount of the planned closure rate adjustment available under subdivision 6 according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month of January or July, whichever occurs first following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's external fixed payment rate.

(c) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

(d) A facility that has received a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment is computed according to paragraph (a).

(e) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the commissioner shall recalculate planned closure rate adjustments for facilities that delicense beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar amount. The recalculated planned closure rate adjustment is effective from the date the per bed dollar amount is increased.

(f) For a nursing facility that is ceasing operations through delicensure and decertification of all beds within the facility, the planned closure rate adjustment under this section is effective on the first day of the month following completion of closure of the facility designated for closure in the application and becomes part of any assigned nursing facility's external fixed payment rate.

Sec. 56. Minnesota Statutes 2016, section 256R.41, is amended to read:

256R.41 SINGLE-BED ROOM INCENTIVE.

(a) Beginning July 1, 2005, the operating payment rate for nursing facilities reimbursed under this chapter shall be increased by 20 percent multiplied by the ratio of the number of new single-bed rooms created divided by the number of active beds on July 1, 2005, for each bed closure that results in the creation of a single-bed room after July 1, 2005. The commissioner may implement rate adjustments for up to 3,000 new single-bed rooms each year. For eligible bed closures for which the commissioner receives a notice from a facility ~~during a calendar quarter~~ that a bed has been delicensed and a new single-bed room has been established, the rate adjustment in this paragraph shall be effective on either the first day of the ~~second~~ month of January or July, whichever occurs first following ~~that calendar quarter~~ the date of the bed delicensure.

(b) A nursing facility is prohibited from discharging residents for purposes of establishing single-bed rooms. A nursing facility must submit documentation to the commissioner in a form prescribed by the commissioner, certifying the occupancy status of beds closed to create single-bed rooms. In the event that the commissioner determines that a facility has discharged a resident for purposes of establishing a single-bed room, the commissioner shall not provide a rate adjustment under paragraph (a).

Sec. 57. Minnesota Statutes 2016, section 256R.47, is amended to read:

256R.47 RATE ADJUSTMENT FOR CRITICAL ACCESS NURSING FACILITIES.

(a) The commissioner, in consultation with the commissioner of health, may designate certain nursing facilities as critical access nursing facilities. The designation shall be granted on a competitive basis, within the limits of funds appropriated for this purpose.

(b) The commissioner shall request proposals from nursing facilities every two years. Proposals must be submitted in the form and according to the timelines established by the commissioner. In selecting applicants to designate, the commissioner, in consultation with the commissioner of health, and with input from stakeholders, shall develop criteria designed to preserve access to nursing facility services in isolated areas, rebalance long-term care, and improve quality. To the extent practicable, the commissioner shall ensure an even distribution of designations across the state.

(c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing facilities designated as critical access nursing facilities:

(1) partial rebasing, with the commissioner allowing a designated facility operating payment rates being the sum of up to 60 percent of the operating payment rate determined in accordance with section 256R.21, subdivision 3, and at least 40 percent, with the sum of the two portions being equal to 100 percent, of the operating payment rate that would have been allowed had the facility not been designated. The commissioner may adjust these percentages by up to 20 percent and may approve a request for less than the amount allowed;

(2) enhanced payments for leave days. Notwithstanding section 256R.43, upon designation as a critical access nursing facility, the commissioner shall limit payment for leave days to 60 percent of that nursing facility's total payment rate for the involved resident, and shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 90 percent;

(3) two designated critical access nursing facilities, with up to 100 beds in active service, may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner of health shall consider each waiver request independently based on the criteria under Minnesota Rules, part 4658.0040;

(4) the minimum threshold under section 256B.431, subdivision 15, paragraph (e), shall be 40 percent of the amount that would otherwise apply; and

(5) the quality-based rate limits under section 256R.23, subdivisions 5 to 7, apply to designated critical access nursing facilities.

(d) Designation of a critical access nursing facility is for a period of two years, after which the benefits allowed under paragraph (c) shall be removed. Designated facilities may apply for continued designation.

(e) This section is suspended and no state or federal funding shall be appropriated or allocated for the purposes of this section from January 1, 2016, to December 31, ~~2017~~ 2019.

Sec. 58. Minnesota Statutes 2016, section 256R.49, is amended to read:

256R.49 RATE ADJUSTMENTS FOR COMPENSATION-RELATED COSTS FOR MINIMUM WAGE CHANGES.

Subdivision 1. **Rate adjustments for compensation-related costs.** (a) ~~Operating~~ Payment rates of all nursing facilities that are reimbursed under this chapter shall be increased effective for rate years beginning on and after October 1, 2014, to address changes in compensation costs for nursing facility employees ~~paid less than $14 per hour~~ in accordance with this section. Rate increases provided under this section before October 1, 2016, expire effective January 1, 2018. Rate increases provided on or after October 1, 2016, expire two years after the effective date of the rate increases.

(b) Nursing facilities that receive approval of the applications in subdivision 2 must receive rate adjustments according to subdivision 4. ~~The rate adjustments must be used to pay compensation costs for nursing facility employees paid less than $14 per hour.~~

Subd. 2. **Application process.** To receive a rate adjustment, nursing facilities must submit applications to the commissioner in a form and manner determined by the commissioner. The applications for the rate adjustments shall include specified data, and spending plans that describe how the funds from the rate adjustments will be allocated for compensation to employees ~~paid less than $14 per hour~~. The applications must be submitted within three months of the effective date of any ~~operating~~ payment rate adjustment under this section. The commissioner may request any additional information needed to determine the rate adjustment within three weeks of receiving a complete application. The nursing facility must provide any additional information requested by the commissioner within six months of the effective date of any ~~operating~~ payment rate adjustment under this section. The commissioner may waive the deadlines in this section under extraordinary circumstances.

Subd. 3. **Additional application requirements for facilities with employees represented by an exclusive bargaining representative.** For nursing facilities in which

employees are represented by an exclusive bargaining representative, the commissioner shall approve the applications submitted under subdivision 2 only upon receipt of a letter or letters of acceptance of the spending plans in regard to members of the bargaining unit, signed by the exclusive bargaining agent and dated after May 31, 2014. Upon receipt of the letter or letters of acceptance, the commissioner shall deem all requirements of this section as having been met in regard to the members of the bargaining unit.

Subd. 4. **Determination of the rate adjustments for compensation-related costs.** Based on the application in subdivision 2, the commissioner shall calculate the allowable annualized compensation costs by adding the totals of clauses (1)~~,~~ and (2)~~, and (3)~~. The result must be divided by the ~~standardized or~~ sum of the facility's resident days from the most recently available cost report to determine per day amounts, which must be included in the ~~operating portion~~ external fixed costs payment rate of the total payment rate ~~and allocated to direct care or other operating as determined by the commissioner~~:

(1) the sum of the difference between $9.50 and any hourly wage rate less than $9.50 for October 1, 2016; and between the indexed value of the minimum wage, as defined in section 177.24, subdivision 1, paragraph (f), or any other minimum wage implemented in statute or by any local ordinance, and any hourly wage less than that indexed value for rate years beginning on and after ~~October 1, 2017~~ January 1, 2018; multiplied by the number of compensated hours at that wage rate; and

~~(2) using wages and hours in effect during the first three months of calendar year 2014, beginning with the first pay period beginning on or after January 1, 2014; 22.2 percent of the sum of items (i) to (viii) for October 1, 2016;~~

~~(i) for all compensated hours from $8 to $8.49 per hour, the number of compensated hours is multiplied by $0.13;~~

~~(ii) for all compensated hours from $8.50 to $8.99 per hour, the number of compensated hours is multiplied by $0.25;~~

~~(iii) for all compensated hours from $9 to $9.49 per hour, the number of compensated hours is multiplied by $0.38;~~

~~(iv) for all compensated hours from $9.50 to $10.49 per hour, the number of compensated hours is multiplied by $0.50;~~

~~(v) for all compensated hours from $10.50 to $10.99 per hour, the number of compensated hours is multiplied by $0.40;~~

~~(vi) for all compensated hours from $11 to $11.49 per hour, the number of compensated hours is multiplied by $0.30;~~

~~(vii) for all compensated hours from $11.50 to $11.99 per hour, the number of compensated hours is multiplied by $0.20; and~~

~~(viii) for all compensated hours from $12 to $13 per hour, the number of compensated hours is multiplied by $0.10; and~~

~~(3)~~ (2) the sum of the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, pensions, and contributions to employee retirement accounts attributable to the amounts in ~~clauses~~ clause (1) ~~and (2)~~.

Sec. 59. Minnesota Statutes 2016, section 256R.53, subdivision 2, is amended to read:

Subd. 2. **Nursing ~~facility~~ facilities in ~~Breckenridge~~ border cities.** The operating payment rate of a nonprofit nursing facility that exists on January 1, 2015, is located within the boundaries of the ~~city~~ cities of Breckenridge or Moorhead, and is reimbursed under this chapter, is equal to the greater of:

(1) the operating payment rate determined under section 256R.21, subdivision 3; or

(2) the median case mix adjusted rates, including comparable rate components as determined by the median case mix adjusted rates, including comparable rate components as determined by the commissioner, for the equivalent case mix indices of the nonprofit nursing facility or facilities located in an adjacent city in another state and in cities contiguous to the adjacent city. The commissioner shall make the comparison required in this subdivision on November 1 of each year and shall apply it to the rates to be effective on the following January 1. The Minnesota facility's operating payment rate with a case mix index of 1.0 is computed by dividing the adjacent city's nursing facility or facilities' median operating payment rate with an index of 1.02 by 1.02. If the adjustments under this subdivision result in a rate that exceeds the limits in section 256R.23, subdivision 5, and whose costs exceed the rate in section 256R.24, subdivision 3, in a given rate year, the facility's rate shall not be subject to the limits in section 256R.23, subdivision 5, and shall not be limited to the rate established in section 256R.24, subdivision 3, for that rate year.

EFFECTIVE DATE. The rate increases for a facility located in Moorhead are effective for the rate year beginning January 1, 2020, and annually thereafter.

Sec. 60. Laws 2015, chapter 71, article 7, section 54, is amended to read:

Sec. 54. **EXPANSION OF CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET METHODOLOGY EXCEPTION.**

(a) No later than September 30, ~~2015~~ 2017, if necessary, the commissioner of human services shall submit an amendment to the Centers for Medicare and Medicaid Services for the home and community-based services waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49, to ~~establish an~~ expand the 2015 exception to the consumer-directed community supports budget methodology to provide up to ~~20~~ 30 percent more funds for both:

(1) consumer-directed community supports participants who ~~have graduated from high school and~~ have a coordinated service and support plan which identifies the need for ~~more services under consumer-directed community supports, either prior to graduation or in order to increase the amount of time a person works or to improve their employment opportunities,~~ an increased amount of services or supports under consumer-directed community supports than the amount they are ~~eligible to receive~~ currently receiving under the ~~current~~ consumer-directed community supports budget methodology~~; and~~:

(i) to increase the amount of time a person works or otherwise improves employment opportunities;

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

(iii) to develop and implement a positive behavior support plan;

(2) home and community-based waiver participants who are currently using licensed ~~services~~ providers for employment supports or services during the day or residential services, either of which cost more annually than the person would spend under a consumer-directed community supports plan for ~~individualized employment supports or services during the day~~ any or all of the supports needed to meet the goals identified in paragraph (a), clause (1).

(b) The exception under paragraph (a) is limited to those persons who can demonstrate either that they will have to ~~leave~~ discontinue using consumer-directed community supports and ~~use~~ accept other non-self-directed waiver services because their ~~need for day or employment~~ supports needed for the goals described in paragraph (a), clause (1), cannot be met within the consumer-directed community supports budget limits ~~or they will move to~~

~~consumer-directed community supports and their services will cost less than services currently being used~~.

(c) The exception under paragraph (a), clause (2), is limited to those persons who can demonstrate that, upon choosing to become a consumer-directed community support participant, the total cost of services, including the exception, will be less than the cost of current waiver services.

EFFECTIVE DATE. The exception under this section is effective October 1, 2017, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 61. **ALZHEIMER'S DISEASE WORKING GROUP.**

Subdivision 1. **Members.** (a) The Minnesota Board on Aging must appoint 16 members to an Alzheimer's disease working group, as follows:

(1) a caregiver of a person who has been diagnosed with Alzheimer's disease;

(2) a person who has been diagnosed with Alzheimer's disease;

(3) two representatives from the nursing facility or senior housing profession;

(4) a representative of the home care or adult day services profession;

(5) two geriatricians, one of whom serves a diverse or underserved community;

(6) a psychologist who specializes in dementia care;

(7) an Alzheimer's researcher;

(8) a representative of the Alzheimer's Association;

(9) two members from community-based organizations serving one or more diverse or underserved communities;

(10) the commissioner of human services or a designee;

(11) the commissioner of health or a designee;

(12) the ombudsman for long-term care or a designee; and

(13) one member of the Minnesota Board on Aging, selected by the board.

(b) The executive director of the Minnesota Board on Aging serves on the working group as a nonvoting member.

(c) The appointing authorities under this subdivision must complete their appointments no later than December 15, 2017.

(d) To the extent practicable, the membership of the working group must reflect the diversity in Minnesota, and must include representatives from rural and metropolitan areas and representatives of different ethnicities, races, genders, ages, cultural groups, and abilities.

Subd. 2. **Duties; recommendations.** The Alzheimer's disease working group must review and revise the 2011 report, Preparing Minnesota for Alzheimer's: the Budgetary, Social and Personal Impacts. The working group shall consider and make recommendations and findings on the following issues as related to Alzheimer's disease or other dementias:

(1) analysis and assessment of public health and health care data to accurately determine trends and disparities in cognitive decline;

(2) public awareness, knowledge, and attitudes, including knowledge gaps, stigma, availability of information, and supportive community environments;

(3) risk reduction, including health education and health promotion on risk factors, safety, and potentially avoidable hospitalizations;

(4) diagnosis and treatment, including early detection, access to diagnosis, quality of dementia care, and cost of treatment;

(5) professional education and training, including geriatric education for licensed health care professionals and dementia-specific training for direct care workers, first responders, and other professionals in communities;

(6) residential services, including cost to families as well as regulation and licensing gaps; and

(7) cultural competence and responsiveness to reduce health disparities and improve access to high-quality dementia care.

Subd. 3. **Meetings.** The Board on Aging must convene the first meeting of the working group no later than January 15, 2018. Before the first meeting, the Board on Aging must designate one member to serve as chair. Meetings of the working group must be open to the public, and to the extent practicable, technological means, such as Web casts, shall be used to reach the greatest number of people throughout the state. The working group may not meet more than five times.

Subd. 4. **Compensation.** Members of the working group serve without compensation, but may be reimbursed for allowed actual and necessary expenses incurred in the performance

of the member's duties for the working group in the same manner and amount as authorized by the commissioner's plan adopted under Minnesota Statutes, section 43A.18, subdivision 2.

Subd. 5. **Administrative support.** The Minnesota Board on Aging shall provide administrative support and arrange meeting space for the working group.

Subd. 6. **Report.** The Board on Aging must submit a report providing the findings and recommendations of the working group, including any draft legislation necessary to implement the recommendations, to the governor and chairs and ranking minority members of the legislative committees with jurisdiction over health care by January 15, 2019.

Subd. 7. **Expiration.** The working group expires June 30, 2019, or the day after the working group submits the report required in subdivision 6, whichever is earlier.

Sec. 62. **CONSUMER-DIRECTED COMMUNITY SUPPORTS REVISED BUDGET METHODOLOGY REPORT.**

(a) The commissioner of human services, in consultation with stakeholders and others including representatives of lead agencies, home and community-based services waiver participants using consumer-directed community supports, advocacy groups, state agencies, the Institute on Community Integration at the University of Minnesota, and service and financial management providers, shall develop a revised consumer-directed community supports budget methodology. The new methodology shall be based on (1) the costs of providing services as reflected by the wage and other relevant components incorporated in the disability waiver rate formulas under chapter 256B, and (2) state-to-county waiver-funding methodologies. The new methodology should develop individual consumer-directed community supports budgets comparable to those provided for similar needs individuals if paying for non-consumer-directed community supports waiver services.

(b) By December 15, 2018, the commissioner shall report a revised consumer-directed community supports budget methodology, including proposed legislation and funding necessary to implement the new methodology, to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over health and human services.

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

Sec. 63. **DIRECTION TO COMMISSIONER; TELECOMMUNICATION EQUIPMENT PROGRAM.**

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

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

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

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

The commissioner shall also provide draft legislative language to accomplish the recommendations. Final recommendations, the final report, and draft legislative language must be approved by both the commissioner and the chair of the Commission of Deaf, Deafblind, and Hard-of-Hearing Minnesotans.

Sec. 64. **DIRECTION TO COMMISSIONER; BILLING FOR MENTAL HEALTH SERVICES.**

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

Sec. 65. **ELECTRONIC SERVICE DELIVERY DOCUMENTATION SYSTEM.**

Subdivision 1. **Documentation; establishment.** The commissioner of human services shall establish implementation requirements and standards for an electronic service delivery documentation system to comply with the 21st Century Cures Act, Public Law 114-255.

Subd. 2. **Definitions.** (a) For purposes of this section, the terms in this subdivision have the meanings given them.

(b) "Electronic service delivery documentation" means the electronic documentation of the:

(1) type of service performed;

(2) individual receiving the service;

(3) date of the service;

(4) location of the service delivery;

(5) individual providing the service; and

(6) time the service begins and ends.

(c) "Electronic service delivery documentation system" means a system that provides electronic service delivery documentation that complies with the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision 3.

(d) "Service" means one of the following:

(1) personal care assistance services as defined in Minnesota Statutes, section 256B.0625, subdivision 19a, and provided according to Minnesota Statutes, section 256B.0659; or

(2) community first services and supports under Minnesota Statutes, section 256B.85.

Subd. 3. **Requirements.** (a) In developing implementation requirements for an electronic service delivery documentation system, the commissioner shall consider electronic visit verification systems and other electronic service delivery documentation methods. The commissioner shall convene stakeholders that will be impacted by an electronic service delivery system, including service providers and their representatives, service recipients and their representatives, and, as appropriate, those with expertise in the development and operation of an electronic service delivery documentation system, to ensure that the requirements:

(1) are minimally administratively and financially burdensome to a provider;

(2) are minimally burdensome to the service recipient and the least disruptive to the service recipient in receiving and maintaining allowed services;

(3) consider existing best practices and use of electronic service delivery documentation;

(4) are conducted according to all state and federal laws;

(5) are effective methods for preventing fraud when balanced against the requirements of clauses (1) and (2); and

(6) are consistent with the Department of Human Services' policies related to covered services, flexibility of service use, and quality assurance.

(b) The commissioner shall make training available to providers on the electronic service delivery documentation system requirements.

(c) The commissioner shall establish baseline measurements related to preventing fraud and establish measures to determine the effect of electronic service delivery documentation requirements on program integrity.

Subd. 4. **Legislative report.** (a) The commissioner shall submit a report by January 15, 2018, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services with recommendations, based on the requirements of subdivision 3, to establish electronic service delivery documentation system requirements and standards. The report shall identify:

(1) the essential elements necessary to operationalize a base-level electronic service delivery documentation system to be implemented by January 1, 2019; and

(2) enhancements to the base-level electronic service delivery documentation system to be implemented by January 1, 2019, or after, with projected operational costs and the costs and benefits for system enhancements.

(b) The report must also identify current regulations on service providers that are either inefficient, minimally effective, or will be unnecessary with the implementation of an electronic service delivery documentation system.

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

Sec. 66. **TRANSPORTATION STUDY.**

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

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

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

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

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

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

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

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

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

Sec. 67. **DIRECTION TO COMMISSIONER; ICF/DD PAYMENT RATE STUDY.**

Within available appropriations, the commissioner of human services shall study the intermediate care facility for persons with developmental disabilities payment rates under Minnesota Statutes, sections 256B.5011 to 256B.5013, and make recommendations on the rate structure to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance by January 15, 2018.

Sec. 68. **FEDERAL WAIVER AMENDMENTS.**

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

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

Sec. 69. **EXCEPTION TO THE BUDGET METHODOLOGY FOR PERSONS LEAVING INSTITUTIONS AND CRISIS RESIDENTIAL SETTINGS.**

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

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

(2) requires services that are more expensive than appropriate less-restrictive services using the consumer-directed community supports option.

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

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

Sec. 70. **REPEALER.**

(a) Minnesota Statutes 2016, sections 256C.23, subdivision 3; 256C.233, subdivision 4; and 256C.25, subdivisions 1 and 2, are repealed.

(b) Minnesota Statutes 2016, section 256B.4914, subdivision 16, is repealed effective January 1, 2018.

ARTICLE 3

HEALTH DEPARTMENT AND PUBLIC HEALTH

Section 1. **[144.059] PALLIATIVE CARE ADVISORY COUNCIL.**

Subdivision 1. **Establishment.** The Palliative Care Advisory Council is established to advise and assist the commissioner of health regarding improving the quality and delivery of patient-centered and family-focused palliative care.

Subd. 2. **Membership.** (a) The council shall consist of 18 public members and four members of the legislature.

(b) The commissioner shall appoint 18 public members, including at least the following:

(1) two physicians, of which one is certified by the American Board of Hospice and Palliative Medicine;

(2) two registered nurses or advanced practice registered nurses, of which one is certified by the National Board for Certification of Hospice and Palliative Nurses;

(3) one care coordinator experienced in working with people with serious or chronic illness and their families;

(4) one spiritual counselor experienced in working with people with serious or chronic illness and their families;

(5) three licensed health professionals, such as complementary and alternative health care practitioners, dietitians or nutritionists, pharmacists, or physical therapists, who are neither physicians nor nurses, but who have experience as members of a palliative care interdisciplinary team working with people with serious or chronic illness and their families;

(6) one licensed social worker experienced in working with people with serious or chronic illness and their families;

(7) four patients or personal caregivers experienced with serious or chronic illness;

(8) one representative of a health plan company; and

(9) one physician assistant that is a member of the American Academy of Hospice and Palliative Medicine.

(c) The Subcommittee on Committees of the Committee on Rules and Administration shall appoint one member of the senate, the minority leader in the senate shall appoint one member of the senate, the speaker of the house shall appoint one member of the house of representatives, and the minority leader in the house of representatives shall appoint one member of the house of representatives.

(d) Council membership must include, where possible, representation that is racially, culturally, linguistically, geographically, and economically diverse.

(e) The council must include at least six members who reside outside Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Mille Lacs, Ramsey, Scott, Sherburne, Sibley, Stearns, Washington, or Wright Counties.

(f) Council membership must include health professionals who have palliative care work experience or expertise in palliative care delivery models in a variety of inpatient, outpatient,

and community settings, including acute care, long-term care, or hospice, with a variety of populations, including pediatric, youth, and adult patients.

(g) To the extent possible, council membership must include persons who have experience in palliative care research, palliative care instruction in a medical or nursing school setting, palliative care services for veterans as a provider or recipient, or pediatric care.

Subd. 3. **Term.** Members of the council shall serve for a term of three years and may be reappointed. Members shall serve until their successors have been appointed.

Subd. 4. **Administration.** The commissioner or the commissioner's designee shall provide meeting space and administrative services for the council.

Subd. 5. **Initial appointments and first meeting.** The appointing authorities shall appoint the first members of the council by July 1, 2017. The commissioner shall convene the first meeting by September 15, 2017, and the commissioner or the commissioner's designee shall act as chair until the council elects a chair at its first meeting.

Subd. 6. **Chairs.** At the council's first meeting, and biannually thereafter, the members shall elect a chair and a vice-chair whose duties shall be established by the council.

Subd. 7. **Meeting.** The council chair shall fix a time and place for regular meetings of the council, which shall meet at least twice yearly.

Subd. 8. **No compensation.** Public members of the council serve without compensation, except for reimbursement from the commissioner for allowed actual and necessary expenses incurred in the performance of the public member's council duties.

Subd. 9. **Duties.** (a) The council shall consult with and advise the commissioner on matters related to the establishment, maintenance, operation, and outcomes evaluation of palliative care initiatives in the state.

(b) By February 15 of each year, the council shall prepare and submit to the chairs and ranking minority members of the committees of the senate and the house of representatives with primary jurisdiction over health care a report containing a description of:

(1) the advisory committee's assessment of the availability of palliative care in the state;

(2) the advisory committee's analysis of barriers to greater access to palliative care; and

(3) recommendations for legislative action.

(c) The Department of Health shall publish the report each year on the department's Web site.

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

Sec. 2. **[144.1215] AUTHORIZATION TO USE HANDHELD DENTAL X-RAY EQUIPMENT.**

Subdivision 1. **Definition; handheld dental x-ray equipment.** For purposes of this section, "handheld dental x-ray equipment" means x-ray equipment that is used to take dental radiographs, is designed to be handheld during operation, and is operated by an individual authorized to take dental radiographs under chapter 150A.

Subd. 2. **Use authorized.** (a) Handheld dental x-ray equipment may be used if the equipment:

(1) has been approved for human use by the United States Food and Drug Administration and is being used in a manner consistent with that approval; and

(2) utilizes a backscatter shield that:

(i) is composed of a leaded polymer or a substance with a substantially equivalent protective capacity;

(ii) has at least 0.25 millimeters of lead or lead-shielding equivalent; and

(iii) is permanently affixed to the handheld dental x-ray equipment.

(b) The use of handheld dental x-ray equipment is prohibited if the equipment's backscatter shield is broken or not permanently affixed to the system.

(c) The use of handheld dental x-ray equipment shall not be limited to situations in which it is impractical to transfer the patient to a stationary x-ray system.

(d) Handheld dental x-ray equipment must be stored when not in use, by being secured in a restricted, locked area of the facility.

(e) Handheld dental x-ray equipment must be calibrated initially and at intervals that must not exceed 24 months. Calibration must include the test specified in Minnesota Rules, part 4732.1100, subpart 11.

(f) Notwithstanding Minnesota Rules, part 4732.0880, subpart 2, item C, the tube housing and the position-indicating device of handheld dental x-ray equipment may be handheld during an exposure.

Subd. 3. **Exemptions from certain shielding requirements.** Handheld dental x-ray equipment used according to this section and according to manufacturer instructions is exempt from the following requirements for the equipment:

(1) shielding requirements in Minnesota Rules, part 4732.0365, item B; and

(2) requirements for the location of the x-ray control console or utilization of a protective barrier in Minnesota Rules, part 4732.0800, subpart 2, item B, subitems (2) and (3), provided the equipment utilizes a backscatter shield that satisfies the requirements in subdivision 2, paragraph (a), clause (2).

Subd. 4. **Compliance with rules.** A registrant using handheld dental x-ray equipment shall otherwise comply with Minnesota Rules, chapter 4732.

Sec. 3. Minnesota Statutes 2016, section 144.1501, subdivision 2, is amended to read:

Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program:

(1) for medical residents and mental health professionals agreeing to practice in designated rural areas or underserved urban communities or specializing in the area of pediatric psychiatry;

(2) for midlevel practitioners agreeing to practice in designated rural areas or to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(3) for nurses who agree to practice in a Minnesota nursing home; an intermediate care facility for persons with developmental disability; ~~or~~ a hospital if the hospital owns and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked by the nurse is in the nursing home; a housing with services establishment as defined in section 144D.01, subdivision 4; or a home care provider as defined in section 144A.43, subdivision 4; or agree to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(4) for other health care technicians agreeing to teach at least 12 credit hours, or 720 hours per year in their designated field in a postsecondary program at the undergraduate level or the equivalent at the graduate level. The commissioner, in consultation with the Healthcare Education-Industry Partnership, shall determine the health care fields where the need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory technology, radiologic technology, and surgical technology;

(5) for pharmacists, advanced dental therapists, dental therapists, and public health nurses who agree to practice in designated rural areas; and

(6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51, chapter 303.

(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

Sec. 4. **[144.1504] SENIOR CARE WORKFORCE INNOVATION GRANT PROGRAM.**

Subdivision 1. **Establishment.** The senior care workforce innovation grant program is established to assist eligible applicants to fund pilot programs or expand existing programs that increase the pool of caregivers working in the field of senior care services.

Subd. 2. **Competitive grants.** The commissioner shall make competitive grants available to eligible applicants to expand the workforce for senior care services.

Subd. 3. **Eligibility.** (a) Eligible applicants must recruit and train individuals to work with individuals who are primarily 65 years of age or older and receiving services through:

(1) a home and community-based setting, including housing with services establishments as defined in section 144D.01, subdivision 4;

(2) adult day care as defined in section 245A.02, subdivision 2a;

(3) home care services as defined in section 144A.43, subdivision 3; or

(4) a nursing home as defined in section 144A.01, subdivision 5.

(b) Applicants must apply for a senior care workforce innovation grant as specified in subdivision 4.

Subd. 4. **Application.** (a) Eligible applicants must apply for a grant on the forms and according to the timelines established by the commissioner.

(b) Each applicant must propose a project or initiative to expand the number of workers in the field of senior care services. At a minimum, a proposal must include:

(1) a description of the senior care workforce innovation project or initiative being proposed, including the process by which the applicant will expand the senior care workforce;

(2) whether the applicant is proposing to target the proposed project or initiative to any of the groups described in paragraph (c);

(3) information describing the applicant's current senior care workforce project or initiative, if applicable;

(4) the amount of funding the applicant is seeking through the grant program;

(5) any other sources of funding the applicant has for the project or initiative;

(6) a proposed budget detailing how the grant funds will be spent; and

(7) outcomes established by the applicant to measure the success of the project or initiative.

Subd. 5. **Commissioner's duties; requests for proposals; grantee selections.** (a) By September 1, 2017, and annually thereafter, the commissioner shall publish a request for proposals in the State Register specifying applicant eligibility requirements, qualifying senior care workforce innovation program criteria, applicant selection criteria, documentation required for program participation, maximum award amount, and methods of evaluation.

(b) Priority must be given to proposals that target employment of individuals who have multiple barriers to employment, individuals who have been unemployed long-term, and veterans.

(c) The commissioner shall determine the maximum award for grants and make grant selections based on the information provided in the grant application, including the targeted employment population, the applicant's proposed budget, the proposed measurable outcomes, and other criteria as determined by the commissioner.

Subd. 6. **Grant funding.** Notwithstanding any law or rule to the contrary, funds awarded to grantees in a grant agreement under this section do not lapse until the grant agreement expires.

Subd. 7. **Reporting requirements.** (a) Grant recipients shall report to the commissioner on the forms and according to the timelines established by the commissioner.

(b) The commissioner shall report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over health by January 15, 2019, and annually thereafter, on the grant program. The report must include:

(1) information on each grant recipient;

(2) a summary of all projects or initiatives undertaken with each grant;

(3) the measurable outcomes established by each grantee, an explanation of the evaluation process used to determine whether the outcomes were met, and the results of the evaluation; and

(4) an accounting of how the grant funds were spent.

(c) During the grant period, the commissioner may require and collect from grant recipients additional information necessary to evaluate the grant program.

Sec. 5. **[144.1505] PRIMARY CARE AND MENTAL HEALTH PROFESSIONS CLINICAL TRAINING EXPANSION GRANT PROGRAM.**

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

(1) "eligible advanced practice registered nurse program" means a program that is located in Minnesota and is currently accredited as a master's, doctoral, or postgraduate level advanced practice registered nurse program by the Commission on Collegiate Nursing Education or by the Accreditation Commission for Education in Nursing, or is a candidate for accreditation;

(2) "eligible dental therapy program" means a dental therapy education program or advanced dental therapy education program that is located in Minnesota and is either:

(i) approved by the Board of Dentistry; or

(ii) currently accredited by the Commission on Dental Accreditation;

(3) "eligible mental health professional program" means a program that is located in Minnesota and is listed as a mental health professional training program by the appropriate accrediting body for clinical social work, psychology, marriage and family therapy, or licensed professional clinical counseling, or is a candidate for accreditation;

(4) "eligible physician assistant program" means a program that is located in Minnesota and is currently accredited as a physician assistant program by the Accreditation Review Commission on Education for the Physician Assistant, or is a candidate for accreditation;

(5) "eligible pharmacy program" means a program that is located in Minnesota and is currently accredited as a doctor of pharmacy program by the Accreditation Council on Pharmacy Education;

(6) "mental health professional" means an individual providing clinical services in the treatment of mental illness who meets one of the definitions in section 245.462, subdivision 18; and

(7) "project" means a project to establish or expand clinical training for physician assistants, advanced practice registered nurses, pharmacists, dental therapists, advanced dental therapists, or mental health professionals in Minnesota.

Subd. 2. **Program.** (a) The commissioner of health shall award health professional training site grants to eligible physician assistant, advanced practice registered nurse, pharmacy, dental therapy, and mental health professional programs to plan and implement expanded clinical training. A planning grant shall not exceed $75,000, and a training grant shall not exceed $150,000 for the first year, $100,000 for the second year, and $50,000 for the third year per program.

(b) Funds may be used for:

(1) establishing or expanding clinical training for physician assistants, advanced practice registered nurses, pharmacists, dental therapists, advanced dental therapists, and mental health professionals in Minnesota;

(2) recruitment, training, and retention of students and faculty;

(3) connecting students with appropriate clinical training sites, internships, practicums, or externship activities;

(4) travel and lodging for students;

(5) faculty, student, and preceptor salaries, incentives, or other financial support;

(6) development and implementation of cultural competency training;

(7) evaluations;

(8) training site improvements, fees, equipment, and supplies required to establish, maintain, or expand a physician assistant, advanced practice registered nurse, pharmacy, dental therapy, or mental health professional training program; and

(9) supporting clinical education in which trainees are part of a primary care team model.

Subd. 3. **Applications.** Eligible physician assistant, advanced practice registered nurse, pharmacy, dental therapy, and mental health professional programs seeking a grant shall apply to the commissioner. Applications must include a description of the number of additional students who will be trained using grant funds; attestation that funding will be used to support an increase in the number of clinical training slots; a description of the problem that the proposed project will address; a description of the project, including all costs associated with the project, sources of funds for the project, detailed uses of all funds for the project, and the results expected; and a plan to maintain or operate any component

included in the project after the grant period. The applicant must describe achievable objectives, a timetable, and roles and capabilities of responsible individuals in the organization.

Subd. 4. **Consideration of applications.** The commissioner shall review each application to determine whether or not the application is complete and whether the program and the project are eligible for a grant. In evaluating applications, the commissioner shall score each application based on factors including, but not limited to, the applicant's clarity and thoroughness in describing the project and the problems to be addressed, the extent to which the applicant has demonstrated that the applicant has made adequate provisions to ensure proper and efficient operation of the training program once the grant project is completed, the extent to which the proposed project is consistent with the goal of increasing access to primary care and mental health services for rural and underserved urban communities, the extent to which the proposed project incorporates team-based primary care, and project costs and use of funds.

Subd. 5. **Program oversight.** The commissioner shall determine the amount of a grant to be given to an eligible program based on the relative score of each eligible program's application, other relevant factors discussed during the review, and the funds available to the commissioner. Appropriations made to the program do not cancel and are available until expended. During the grant period, the commissioner may require and collect from programs receiving grants any information necessary to evaluate the program.

Sec. 6. Minnesota Statutes 2016, section 144.1506, is amended to read:

144.1506 ~~PRIMARY CARE~~ PHYSICIAN RESIDENCY EXPANSION GRANT PROGRAM.

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

(1) "eligible ~~primary care~~ physician residency program" means a program that meets the following criteria:

(i) is located in Minnesota;

(ii) trains medical residents in the specialties of family medicine, general internal medicine, general pediatrics, psychiatry, geriatrics, ~~or~~ general surgery, obstetrics and gynecology, or other physician specialties with training programs that incorporate rural training components; and

(iii) is accredited by the Accreditation Council for Graduate Medical Education or presents a credible plan to obtain accreditation;

(2) "eligible project" means a project to establish a new eligible ~~primary care~~ physician residency program or create at least one new residency slot in an existing eligible ~~primary care~~ physician residency program; and

(3) "new residency slot" means the creation of a new residency position and the execution of a contract with a new resident in a residency program.

Subd. 2. **Expansion grant program.** (a) The commissioner of health shall award ~~primary care~~ physician residency expansion grants to eligible ~~primary care~~ physician residency programs to plan and implement new residency slots. A planning grant shall not exceed $75,000, and a training grant shall not exceed $150,000 per new residency slot for the first year, $100,000 for the second year, and $50,000 for the third year of the new residency slot.

(b) Funds may be spent to cover the costs of:

(1) planning related to establishing an accredited ~~primary care~~ physician residency program;

(2) obtaining accreditation by the Accreditation Council for Graduate Medical Education or another national body that accredits residency programs;

(3) establishing new residency programs or new resident training slots;

(4) recruitment, training, and retention of new residents and faculty;

(5) travel and lodging for new residents;

(6) faculty, new resident, and preceptor salaries related to new residency slots;

(7) training site improvements, fees, equipment, and supplies required for new ~~primary care~~ physician resident training slots; and

(8) supporting clinical education in which trainees are part of a primary care team model.

Subd. 3. **Applications for expansion grants.** Eligible ~~primary care~~ physician residency programs seeking a grant shall apply to the commissioner. Applications must include the number of new ~~primary care~~ physician residency slots planned or under contract; attestation that funding will be used to support an increase in the number of available residency slots; a description of the training to be received by the new residents, including the location of training; a description of the project, including all costs associated with the project; all sources of funds for the project; detailed uses of all funds for the project; the results expected; and a plan to maintain the new residency slot after the grant period. The applicant must describe achievable objectives, a timetable, and roles and capabilities of responsible individuals in the organization.

Subd. 4. **Consideration of expansion grant applications.** The commissioner shall review each application to determine whether or not the residency program application is complete and whether the proposed new residency program and any new residency slots are eligible for a grant. The commissioner shall award grants to support up to six family medicine, general internal medicine, or general pediatrics residents; four psychiatry residents; two geriatrics residents; ~~and two~~ four general surgery residents; two obstetrics and gynecology residents; and four specialty physician residents participating in training programs that incorporate rural training components. If insufficient applications are received from any eligible specialty, funds may be redistributed to applications from other eligible specialties.

Subd. 5. **Program oversight.** During the grant period, the commissioner may require and collect from grantees any information necessary to evaluate the program. Appropriations made to the program do not cancel and are available until expended.

Sec. 7. **[144.397] STATEWIDE TOBACCO QUITLINE SERVICES.**

(a) The commissioner of health shall administer, or contract for the administration of, a statewide tobacco quitline service to assist Minnesotans who are seeking advice or services to help them quit using tobacco products. The commissioner shall establish statewide public awareness activities to inform the public of the availability of the service and encourage the public to utilize the services because of the dangers and harm of tobacco use and dependence.

(b) Services to be provided include, but are not limited to:

(1) telephone-based coaching and counseling;

(2) referrals;

(3) written materials mailed upon request;

(4) Web-based texting or e-mail services; and

(5) free Food and Drug Administration-approved tobacco cessation medications.

(c) Services provided must be consistent with evidence-based best practices in tobacco cessation services. Services provided must be coordinated with employer, health plan company, and private sector tobacco prevention and cessation services that may be available to individuals depending on their employment or health coverage.

Sec. 8. Minnesota Statutes 2016, section 144.551, subdivision 1, is amended to read:

Subdivision 1. **Restricted construction or modification.** (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from

one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; and (iv) the relocation or redistribution does not involve the construction of a new hospital building;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice County that primarily serves adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement hospital, either at the time of construction of the initial building or as the result of future expansion, will not exceed 70 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex operated by the commissioner of human services; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus;

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27 beds, of which 12 serve mental health needs, may be transferred from Hennepin County Medical Center to Regions Hospital under this clause;

(13) a construction project involving the addition of up to 31 new beds in an existing nonfederal hospital in Beltrami County;

(14) a construction project involving the addition of up to eight new beds in an existing nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

(15) a construction project involving the addition of 20 new hospital beds used for rehabilitation services in an existing hospital in Carver County serving the southwest

suburban metropolitan area. Beds constructed under this clause shall not be eligible for reimbursement under medical assistance or MinnesotaCare;

(16) a project for the construction or relocation of up to 20 hospital beds for the operation of up to two psychiatric facilities or units for children provided that the operation of the facilities or units have received the approval of the commissioner of human services;

(17) a project involving the addition of 14 new hospital beds to be used for rehabilitation services in an existing hospital in Itasca County;

(18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County that closed 20 rehabilitation beds in 2002, provided that the beds are used only for rehabilitation in the hospital's current rehabilitation building. If the beds are used for another purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

(19) a critical access hospital established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33, to the extent that the critical access hospital does not seek to exceed the maximum number of beds permitted such hospital under federal law;

(20) notwithstanding section 144.552, a project for the construction of a new hospital in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

(i) the project, including each hospital or health system that will own or control the entity that will hold the new hospital license, is approved by a resolution of the Maple Grove City Council as of March 1, 2006;

(ii) the entity that will hold the new hospital license will be owned or controlled by one or more not-for-profit hospitals or health systems that have previously submitted a plan or plans for a project in Maple Grove as required under section 144.552, and the plan or plans have been found to be in the public interest by the commissioner of health as of April 1, 2005;

(iii) the new hospital's initial inpatient services must include, but are not limited to, medical and surgical services, obstetrical and gynecological services, intensive care services, orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health services, and emergency room services;

(iv) the new hospital:

(A) will have the ability to provide and staff sufficient new beds to meet the growing needs of the Maple Grove service area and the surrounding communities currently being

served by the hospital or health system that will own or control the entity that will hold the new hospital license;

(B) will provide uncompensated care;

(C) will provide mental health services, including inpatient beds;

(D) will be a site for workforce development for a broad spectrum of health-care-related occupations and have a commitment to providing clinical training programs for physicians and other health care providers;

(E) will demonstrate a commitment to quality care and patient safety;

(F) will have an electronic medical records system, including physician order entry;

(G) will provide a broad range of senior services;

(H) will provide emergency medical services that will coordinate care with regional providers of trauma services and licensed emergency ambulance services in order to enhance the continuity of care for emergency medical patients; and

(I) will be completed by December 31, 2009, unless delayed by circumstances beyond the control of the entity holding the new hospital license; and

(v) as of 30 days following submission of a written plan, the commissioner of health has not determined that the hospitals or health systems that will own or control the entity that will hold the new hospital license are unable to meet the criteria of this clause;

(21) a project approved under section 144.553;

(22) a project for the construction of a hospital with up to 25 beds in Cass County within a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder is approved by the Cass County Board;

(23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing a separately licensed 13-bed skilled nursing facility;

(24) notwithstanding section 144.552, a project for the construction and expansion of a specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients who are under 21 years of age on the date of admission. The commissioner conducted a public interest review of the mental health needs of Minnesota and the Twin Cities metropolitan area in 2008. No further public interest review shall be conducted for the construction or expansion project under this clause;

(25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete; ~~or~~

(26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city of Maple Grove, exclusively for patients who are under 21 years of age on the date of admission, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(ii) this project shall serve patients in the continuing care benefit program under section 256.9693. The project may also serve patients not in the continuing care benefit program; and

(iii) if the project ceases to participate in the continuing care benefit program, the commissioner must complete a subsequent public interest review under section 144.552. If the project is found not to be in the public interest, the license must be terminated six months from the date of that finding. If the commissioner of human services terminates the contract without cause or reduces per diem payment rates for patients under the continuing care benefit program below the rates in effect for services provided on December 31, 2015, the project may cease to participate in the continuing care benefit program and continue to operate without a subsequent public interest review; or

(27) a project involving the addition of 21 new beds in an existing psychiatric hospital in Hennepin County that is exclusively for patients who are under 21 years of age on the date of admission.

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

Sec. 9. **[144.88] MINNESOTA BIOMEDICINE AND BIOETHICS INNOVATION GRANTS.**

Subdivision 1. **Grants.** (a) The commissioner of health, in consultation with interested parties with relevant knowledge and expertise as specified in subdivision 2, shall award grants to entities that apply for a grant under this subdivision to fund innovations and research in biomedicine and bioethics. Grant funds must be used to fund biomedical and bioethical research, and related clinical translation and commercialization activities in this state. Entities applying for a grant must do so in a form and manner specified by the commissioner. The commissioner and interested parties shall use the following criteria to award grants under this subdivision:

(1) the likelihood that the research will lead to a new discovery;

(2) the prospects for commercialization of the research;

(3) the likelihood that the research will strengthen Minnesota's economy through the creation of new businesses, increased public or private funding for research in Minnesota, or attracting additional clinicians and researchers to Minnesota; and

(4) whether the proposed research includes a bioethics research plan to ensure the research is conducted using ethical research practices.

(b) Projects that include the acquisition or use of human fetal tissue are not eligible for grants under this subdivision. For purposes of this paragraph, "human fetal tissue" has the meaning given in United States Code, title 42, section 289g-1(f).

Subd. 2. **Consultation.** In awarding grants under subdivision 1, the commissioner must consult with interested parties who are able to provide the commissioner with technical information, advice, and recommendations on grant projects and awards. Interested parties with whom the commissioner must consult include but are not limited to representatives of the University of Minnesota, Mayo Clinic, and private industries who have expertise in biomedical research, bioethical research, clinical translation, commercialization, and medical venture financing.

Sec. 10. Minnesota Statutes 2016, section 144.99, subdivision 1, is amended to read:

Subdivision 1. **Remedies available.** The provisions of chapters 103I and 157 and sections 115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12), (13), (14), and (15); 144.1201 to 144.1204; 144.121; 144.1215; 144.1222; 144.35; 144.381 to 144.385; 144.411 to 144.417; 144.495; 144.71 to 144.74; 144.9501 to 144.9512; 144.97 to 144.98; 144.992; 326.70 to 326.785; 327.10 to 327.131; and 327.14 to 327.28 and all rules, orders, stipulation agreements, settlements, compliance agreements, licenses, registrations, certificates, and permits adopted or issued by the department or under any other law now in force or later enacted for the preservation of public health may, in addition to provisions in other statutes, be enforced under this section.

Sec. 11. Minnesota Statutes 2016, section 144A.474, subdivision 11, is amended to read:

Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be assessed based on the level and scope of the violations described in paragraph (c) as follows:

(1) Level 1, no fines or enforcement;

(2) Level 2, fines ranging from $0 to $500, in addition to any of the enforcement mechanisms authorized in section 144A.475 for widespread violations;

(3) Level 3, fines ranging from $500 to $1,000, in addition to any of the enforcement mechanisms authorized in section 144A.475; and

(4) Level 4, fines ranging from $1,000 to $5,000, in addition to any of the enforcement mechanisms authorized in section 144A.475.

(b) Correction orders for violations are categorized by both level and scope and fines shall be assessed as follows:

(1) level of violation:

(i) Level 1 is a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety;

(ii) Level 2 is a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death;

(iii) Level 3 is a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death; and

(iv) Level 4 is a violation that results in serious injury, impairment, or death.

(2) scope of violation:

(i) isolated, when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally;

(ii) pattern, when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive; and

(iii) widespread, when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients.

(c) If the commissioner finds that the applicant or a home care provider required to be licensed under sections 144A.43 to 144A.482 has not corrected violations by the date specified in the correction order or conditional license resulting from a survey or complaint investigation, the commissioner may impose a fine. A notice of noncompliance with a correction order must be mailed to the applicant's or provider's last known address. The noncompliance notice must list the violations not corrected.

(d) The license holder must pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a

second fine or suspend the license until the license holder complies by paying the fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(e) A license holder shall promptly notify the commissioner in writing when a violation specified in the order is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order, the commissioner may issue a second fine. The commissioner shall notify the license holder by mail to the last known address in the licensing record that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(f) A home care provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14.

(g) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder shall be liable for payment of the fine.

(h) In addition to any fine imposed under this section, the commissioner may assess costs related to an investigation that results in a final order assessing a fine or other enforcement action authorized by this chapter.

(i) Fines collected under this subdivision shall be deposited in the state government special revenue fund and credited to an account separate from the revenue collected under section 144A.472. Subject to an appropriation by the legislature, the revenue from the fines collected ~~may~~ must be used by the commissioner for special projects to improve home care in Minnesota as recommended by the advisory council established in section 144A.4799.

Sec. 12. Minnesota Statutes 2016, section 144A.4799, subdivision 3, is amended to read:

Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide advice regarding regulations of Department of Health licensed home care providers in this chapter, including advice on the following:

(1) community standards for home care practices;

(2) enforcement of licensing standards and whether certain disciplinary actions are appropriate;

(3) ways of distributing information to licensees and consumers of home care;

(4) training standards;

(5) identifying emerging issues and opportunities in the home care field, including the use of technology in home and telehealth capabilities;

(6) allowable home care licensing modifications and exemptions, including a method for an integrated license with an existing license for rural licensed nursing homes to provide limited home care services in an adjacent independent living apartment building owned by the licensed nursing home; and

(7) recommendations for studies using the data in section 62U.04, subdivision 4, including but not limited to studies concerning costs related to dementia and chronic disease among an elderly population over 60 and additional long-term care costs, as described in section 62U.10, subdivision 6.

(b) The advisory council shall perform other duties as directed by the commissioner.

(c) The advisory council shall annually review the balance of the account in the state government special revenue fund described in section 144A.474, subdivision 11, paragraph (i), and make annual recommendations by January 15 directly to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services regarding appropriations to the commissioner for the purposes in section 144A.474, subdivision 11, paragraph (i).

Sec. 13. Minnesota Statutes 2016, section 144A.70, is amended by adding a subdivision to read:

Subd. 4a. **Nurse.** "Nurse" means a licensed practical nurse as defined in section 148.171, subdivision 8, or a registered nurse as defined in section 148.171, subdivision 20.

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

Sec. 14. Minnesota Statutes 2016, section 144A.70, subdivision 6, is amended to read:

Subd. 6. **Supplemental nursing services agency.** "Supplemental nursing services agency" means a person, firm, corporation, partnership, or association engaged for hire in the business of providing or procuring temporary employment in health care facilities for nurses, nursing assistants, nurse aides, and orderlies~~, and other licensed health professionals~~. Supplemental nursing services agency does not include an individual who only engages in providing the individual's services on a temporary basis to health care facilities. Supplemental nursing services agency does not include a professional home care agency licensed under section 144A.471 that only provides staff to other home care providers.

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

Sec. 15. **[144H.01] DEFINITIONS.**

Subdivision 1. **Application.** The terms defined in this section apply to this chapter.

Subd. 2. **Basic services.** "Basic services" includes but is not limited to:

(1) the development, implementation, and monitoring of a comprehensive protocol of care that is developed in conjunction with the parent or guardian of a medically complex or technologically dependent child and that specifies the medical, nursing, psychosocial, and developmental therapies required by the medically complex or technologically dependent child; and

(2) the caregiver training needs of the child's parent or guardian.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 4. **Licensee.** "Licensee" means an owner of a prescribed pediatric extended care (PPEC) center licensed under this chapter.

Subd. 5. **Medically complex or technologically dependent child.** "Medically complex or technologically dependent child" means a child under 21 years of age who, because of a medical condition, requires continuous therapeutic interventions or skilled nursing supervision which must be prescribed by a licensed physician and administered by, or under the direct supervision of, a licensed registered nurse.

Subd. 6. **Owner.** "Owner" means an individual whose ownership interest provides sufficient authority or control to affect or change decisions regarding the operation of the PPEC center. An owner includes a sole proprietor, a general partner, or any other individual whose ownership interest has the ability to affect the management and direction of the PPEC center's policies.

Subd. 7. **Prescribed pediatric extended care center, PPEC center, or center.** "Prescribed pediatric extended care center," "PPEC center," or "center" means any facility that provides nonresidential basic services to three or more medically complex or technologically dependent children who require such services and who are not related to the owner by blood, marriage, or adoption.

Subd. 8. **Supportive services or contracted services.** "Supportive services or contracted services" include but are not limited to speech therapy, occupational therapy, physical therapy, social work services, developmental services, child life services, and psychology services.

Sec. 16. **[144H.02] LICENSURE REQUIRED.**

A person may not own or operate a prescribed pediatric extended care center in this state unless the person holds a temporary or current license issued under this chapter. A separate license must be obtained for each PPEC center maintained on separate premises, even if the same management operates the PPEC centers. Separate licenses are not required for separate buildings on the same grounds. A center shall not be operated on the same grounds as a child care center licensed under Minnesota Rules, chapter 9503.

Sec. 17. **[144H.03] EXEMPTIONS.**

This chapter does not apply to:

(1) a facility operated by the United States government or a federal agency; or

(2) a health care facility licensed under chapter 144 or 144A.

Sec. 18. **[144H.04] LICENSE APPLICATION AND RENEWAL.**

Subdivision 1. **Licenses.** A person seeking licensure for a PPEC center must submit a completed application for licensure to the commissioner, in a form and manner determined by the commissioner. The applicant must also submit the application fee, in the amount specified in section 144H.05, subdivision 1. Effective January 1, 2018, the commissioner shall issue a license for a PPEC center if the commissioner determines that the applicant and center meet the requirements of this chapter and rules that apply to PPEC centers. A license issued under this subdivision is valid for two years.

Subd. 2. **License renewal.** A license issued under subdivision 1 may be renewed for a period of two years if the licensee:

(1) submits an application for renewal in a form and manner determined by the commissioner, at least 30 days before the license expires. An application for renewal submitted after the renewal deadline date must be accompanied by a late fee in the amount specified in section 144H.05, subdivision 3;

(2) submits the renewal fee in the amount specified in section 144H.05, subdivision 2;

(3) demonstrates that the licensee has provided basic services at the PPEC center within the past two years;

(4) provides evidence that the applicant meets the requirements for licensure; and

(5) provides other information required by the commissioner.

Subd. 3. **License not transferable.** A PPEC center license issued under this section is not transferable to another party. Before acquiring ownership of a PPEC center, a prospective applicant must apply to the commissioner for a new license.

Sec. 19. **[144H.05] FEES.**

Subdivision 1. **Initial application fee.** The initial application fee for PPEC center licensure is $3,820.

Subd. 2. **License renewal.** The fee for renewal of a PPEC center license is $1,800.

Subd. 3. **Late fee.** The fee for late submission of an application to renew a PPEC center license is $25.

Subd. 4. **Change of ownership.** The fee for change of ownership of a PPEC center is $4,200.

Subd. 4. **Nonrefundable; state government special revenue fund.** All fees collected under this chapter are nonrefundable and must be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 20. **[144H.06] APPLICATION OF RULES FOR HOSPICE SERVICES AND RESIDENTIAL HOSPICE FACILITIES.**

Minnesota Rules, chapter 4664, shall apply to PPEC centers licensed under this chapter, except that the following parts, subparts, items, and subitems do not apply:

(1) Minnesota Rules, part 4664.0003, subparts 2, 6, 7, 11, 12, 13, 14, and 38;

(2) Minnesota Rules, part 4664.0008;

(3) Minnesota Rules, part 4664.0010, subparts 3; 4, items A, subitem (6), and B; and 8;

(4) Minnesota Rules, part 4664.0020, subpart 13;

(5) Minnesota Rules, part 4664.0370, subpart 1;

(6) Minnesota Rules, part 4664.0390, subpart 1, items A, C, and E;

(7) Minnesota Rules, part 4664.0420;

(8) Minnesota Rules, part 4664.0425, subparts 3, item A; 4; and 6;

(9) Minnesota Rules, part 4664.0430, subparts 3, 4, 5, 7, 8, 9, 10, 11, and 12;

(10) Minnesota Rules, part 4664.0490; and

(11) Minnesota Rules, part 4664.0520.

Sec. 21. **[144H.07] SERVICES; LIMITATIONS.**

Subdivision 1. **Services.** A PPEC center must provide basic services to medically complex or technologically dependent children, based on a protocol of care established for each child. A PPEC center may provide services up to 14 hours a day and up to six days a week.

Subd. 2. **Limitations.** A PPEC center must comply with the following standards related to services:

(1) a child is prohibited from attending a PPEC center for more than 14 hours within a 24-hour period;

(2) a PPEC center is prohibited from providing services other than those provided to medically complex or technologically dependent children; and

(3) the maximum capacity for medically complex or technologically dependent children at a center shall not exceed 45 children.

Sec. 22. **[144H.08] ADMINISTRATION AND MANAGEMENT.**

Subdivision 1. **Duties of owner.** (a) The owner of a PPEC center shall have full legal authority and responsibility for the operation of the center. A PPEC center must be organized according to a written table of organization, describing the lines of authority and communication to the child care level. The organizational structure must be designed to ensure an integrated continuum of services for the children served.

(b) The owner must designate one person as a center administrator, who is responsible and accountable for overall management of the center.

Subd. 2. **Duties of administrator.** The center administrator is responsible and accountable for overall management of the center. The administrator must:

(1) designate in writing a person to be responsible for the center when the administrator is absent from the center for more than 24 hours;

(2) maintain the following written records, in a place and form and using a system that allows for inspection of the records by the commissioner during normal business hours:

(i) a daily census record, which indicates the number of children currently receiving services at the center;

(ii) a record of all accidents or unusual incidents involving any child or staff member that caused, or had the potential to cause, injury or harm to a person at the center or to center property;

(iii) copies of all current agreements with providers of supportive services or contracted services;

(iv) copies of all current agreements with consultants employed by the center, documentation of each consultant's visits, and written, dated reports; and

(v) a personnel record for each employee, which must include an application for employment, references, employment history for the preceding five years, and copies of all performance evaluations;

(3) develop and maintain a current job description for each employee;

(4) provide necessary qualified personnel and ancillary services to ensure the health, safety, and proper care for each child; and

(5) develop and implement infection control policies that comply with rules adopted by the commissioner regarding infection control.

Sec. 23. **[144H.09] ADMISSION, TRANSFER, AND DISCHARGE POLICIES; CONSENT FORM.**

Subdivision 1. **Written policies.** A PPEC center must have written policies and procedures governing the admission, transfer, and discharge of children.

Subd. 2. **Notice of discharge.** At least ten days prior to a child's discharge from a PPEC center, the PPEC center shall provide notice of the discharge to the child's parent or guardian.

Subd. 3. **Consent form.** A parent or guardian must sign a consent form outlining the purpose of a PPEC center, specifying family responsibilities, authorizing treatment and services, providing appropriate liability releases, and specifying emergency disposition plans, before the child's admission to the center. The center must provide the child's parents or guardians with a copy of the consent form and must maintain the consent form in the child's medical record.

Sec. 24. **[144H.10] MEDICAL DIRECTOR.**

A PPEC center must have a medical director who is a physician licensed in Minnesota and certified by the American Board of Pediatrics.

Sec. 25. **[144H.11] NURSING SERVICES.**

Subdivision 1. **Nursing director.** A PPEC center must have a nursing director who is a registered nurse licensed in Minnesota, holds a current certification in cardiopulmonary

resuscitation, and has at least four years of general pediatric nursing experience, at least one year of which must have been spent caring for medically fragile infants or children in a pediatric intensive care, neonatal intensive care, PPEC center, or home care setting during the previous five years. The nursing director is responsible for the daily operation of the PPEC center.

Subd. 2. **Registered nurses.** A registered nurse employed by a PPEC center must be a registered nurse licensed in Minnesota, hold a current certification in cardiopulmonary resuscitation, and have experience in the previous 24 months in being responsible for the care of acutely ill or chronically ill children.

Subd. 3. **Licensed practical nurses.** A licensed practical nurse employed by a PPEC center must be supervised by a registered nurse and must be a licensed practical nurse licensed in Minnesota, have at least two years of experience in pediatrics, and hold a current certification in cardiopulmonary resuscitation.

Subd. 4. **Other direct care personnel.** (a) Direct care personnel governed by this subdivision include nursing assistants and individuals with training and experience in the field of education, social services, or child care.

(b) All direct care personnel employed by a PPEC center must work under the supervision of a registered nurse and are responsible for providing direct care to children at the center. Direct care personnel must have extensive, documented education and skills training in providing care to infants and toddlers, provide employment references documenting skill in the care of infants and children, and hold a current certification in cardiopulmonary resuscitation.

Sec. 26. **[144H.12] TOTAL STAFFING FOR NURSING SERVICES AND DIRECT CARE PERSONNEL.**

A PPEC center must provide total staffing for nursing services and direct care personnel at a ratio of one staff person for every three children at the center. The staffing ratio required in this section is the minimum staffing permitted.

Sec. 27. **[144H.13] MEDICAL RECORD; PROTOCOL OF CARE.**

A medical record and an individualized nursing protocol of care must be developed for each child admitted to a PPEC center, must be maintained for each child, and must be signed by authorized personnel.

Sec. 28. **[144H.14] QUALITY ASSURANCE PROGRAM.**

A PPEC center must have a quality assurance program, in which quarterly reviews are conducted of the PPEC center's medical records and protocols of care for at least half of the children served by the PPEC center. The quarterly review sample must be randomly selected so each child at the center has an equal opportunity to be included in the review. The committee conducting quality assurance reviews must include the medical director, administrator, nursing director, and three other committee members determined by the PPEC center.

Sec. 29. **[144H.15] INSPECTIONS.**

(a) The commissioner may inspect a PPEC center, including records held at the center, at reasonable times as necessary to ensure compliance with this chapter and the rules that apply to PPEC centers. During an inspection, a center must provide the commissioner with access to all center records.

(b) The commissioner must inspect a PPEC center before issuing or renewing a license under this chapter.

Sec. 30. **[144H.16] COMPLIANCE WITH OTHER LAWS.**

Subdivision 1. **Reporting of maltreatment of minors.** A PPEC center must develop policies and procedures for reporting suspected child maltreatment that fulfill the requirements of section 626.556. The policies and procedures must include the telephone numbers of the local county child protection agency for reporting suspected maltreatment. The policies and procedures specified in this subdivision must be provided to the parents or guardians of all children at the time of admission to the PPEC center and must be available upon request.

Subd. 2. **Crib safety requirements.** A PPEC center must comply with the crib safety requirements in section 245A.146, to the extent they are applicable.

Sec. 31. **[144H.17] DENIAL, SUSPENSION, REVOCATION, REFUSAL TO RENEW A LICENSE.**

(a) The commissioner may deny, suspend, revoke, or refuse to renew a license issued under this chapter for:

(1) a violation of this chapter or rules adopted that apply to PPEC centers; or

(2) an intentional or negligent act by an employee or contractor at the center that detrimentally affects the health or safety of children at the PPEC center.

(b) Prior to any suspension, revocation, or refusal to renew a license, a licensee shall be entitled to a hearing and review as provided in sections 14.57 to 14.69.

Sec. 32. **[144H.18] FINES; CORRECTIVE ACTION PLANS.**

Subdivision 1. **Corrective action plans.** If the commissioner determines that a PPEC center is not in compliance with this chapter or rules that apply to PPEC centers, the commissioner may require the center to submit a corrective action plan that demonstrates a good-faith effort to remedy each violation by a specific date, subject to approval by the commissioner.

Subd. 2. **Fines.** The commissioner may issue a fine to a PPEC center, employee, or contractor if the commissioner determines the center, employee, or contractor violated this chapter or rules that apply to PPEC centers. The fine amount shall not exceed an amount for each violation and an aggregate amount established by the commissioner. The failure to correct a violation by the date set by the commissioner, or a failure to comply with an approved corrective action plan, constitutes a separate violation for each day the failure continues, unless the commissioner approves an extension to a specific date. In determining if a fine is to be imposed and establishing the amount of the fine, the commissioner shall consider:

(1) the gravity of the violation, including the probability that death or serious physical or emotional harm to a child will result or has resulted, the severity of the actual or potential harm, and the extent to which the applicable laws were violated;

(2) actions taken by the owner or administrator to correct violations;

(3) any previous violations; and

(4) the financial benefit to the PPEC center of committing or continuing the violation.

Subd. 3. **Fines for violations of other statutes.** The commissioner shall impose a fine of $250 on a PPEC center, employee, or contractor for each violation by that PPEC center, employee, or contractor of section 245A.146 or 626.556.

Sec. 33. **[144H.19] CLOSING A PPEC CENTER.**

When a PPEC center voluntarily closes, it must, at least 30 days before closure, inform each child's parents or guardians of the closure and when the closure will occur.

Sec. 34. **[144H.20] PHYSICAL ENVIRONMENT.**

Subdivision 1. **General requirements.** A PPEC center shall conform with or exceed the physical environment requirements in this section and the physical environment requirements for day care facilities in Minnesota Rules, part 9502.0425. If the physical environment requirements in this section differ from the physical environment requirements for day care facilities in Minnesota Rules, part 9502.0425, the requirements in this section shall prevail. A PPEC center must have sufficient indoor and outdoor space to accommodate at least six medically complex or technologically dependent children.

Subd. 2. **Specific requirements.** (a) The entrance to a PPEC center must be barrier-free, have a wheelchair ramp, provide for traffic flow with a driveway area for entering and exiting, and have storage space for supplies from home.

(b) A PPEC center must have a treatment room with a medication preparation area. The medication preparation area must contain a work counter, refrigerator, sink with hot and cold running water, and locked storage for biologicals and prescription drugs.

(c) A PPEC center must develop isolation procedures to prevent cross-infections and must have an isolation room with at least one glass area for observation of a child in the isolation room. The isolation room must be at least 100 square feet in size.

(d) A PPEC center must have:

(1) an outdoor play space adjacent to the center of at least 35 square feet per child in attendance at the center, for regular use; or

(2) a park, playground, or play space within 1,500 feet of the center.

(e) A PPEC center must have at least 50 square feet of usable indoor space per child in attendance at the center.

(f) Notwithstanding the Minnesota State Building Code and the Minnesota State Fire Code, a new construction PPEC center or an existing building converted into a PPEC center must meet the requirements of the International Building Code in Minnesota Rules, chapter 1305, for:

(1) Group R, Division 4 occupancy, if serving 12 or fewer children; or

(2) Group E, Division 4 occupancy or Group I, Division 4 occupancy, if serving 13 or more children.

Sec. 35. Minnesota Statutes 2016, section 145.4131, subdivision 1, is amended to read:

Subdivision 1. **Forms.** (a) Within 90 days of July 1, 1998, the commissioner shall prepare a reporting form for use by physicians or facilities performing abortions. A copy of this section shall be attached to the form. A physician or facility performing an abortion shall obtain a form from the commissioner.

(b) The form shall require the following information:

(1) the number of abortions performed by the physician in the previous calendar year, reported by month;

(2) the method used for each abortion;

(3) the approximate gestational age expressed in one of the following increments:

(i) less than nine weeks;

(ii) nine to ten weeks;

(iii) 11 to 12 weeks;

(iv) 13 to 15 weeks;

(v) 16 to 20 weeks;

(vi) 21 to 24 weeks;

(vii) 25 to 30 weeks;

(viii) 31 to 36 weeks; or

(ix) 37 weeks to term;

(4) the age of the woman at the time the abortion was performed;

(5) the specific reason for the abortion, including, but not limited to, the following:

(i) the pregnancy was a result of rape;

(ii) the pregnancy was a result of incest;

(iii) economic reasons;

(iv) the woman does not want children at this time;

(v) the woman's emotional health is at stake;

(vi) the woman's physical health is at stake;

(vii) the woman will suffer substantial and irreversible impairment of a major bodily function if the pregnancy continues;

(viii) the pregnancy resulted in fetal anomalies; or

(ix) unknown or the woman refused to answer;

(6) the number of prior induced abortions;

(7) the number of prior spontaneous abortions;

(8) whether the abortion was paid for by:

(i) private coverage;

(ii) public assistance health coverage; or

(iii) self-pay;

(9) whether coverage was under:

(i) a fee-for-service plan;

(ii) a capitated private plan; or

(iii) other;

(10) complications, if any, for each abortion and for the aftermath of each abortion. Space for a description of any complications shall be available on the form;

(11) the medical specialty of the physician performing the abortion; ~~and~~

(12) if the abortion was performed via telemedicine, the facility code for the patient and the facility code for the physician; and

~~(12)~~ (13) whether the abortion resulted in a born alive infant, as defined in section 145.423, subdivision 4, and:

(i) any medical actions taken to preserve the life of the born alive infant;

(ii) whether the born alive infant survived; and

(iii) the status of the born alive infant, should the infant survive, if known.

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

Sec. 36. Minnesota Statutes 2016, section 145.4716, subdivision 2, is amended to read:

Subd. 2. **Duties of director.** The director of child sex trafficking prevention is responsible for the following:

(1) developing and providing comprehensive training on sexual exploitation of youth for social service professionals, medical professionals, public health workers, and criminal justice professionals;

(2) collecting, organizing, maintaining, and disseminating information on sexual exploitation and services across the state, including maintaining a list of resources on the Department of Health Web site;

(3) monitoring and applying for federal funding for antitrafficking efforts that may benefit victims in the state;

(4) managing grant programs established under sections 145.4716 to 145.4718~~, and~~; 609.3241, paragraph (c), clause (3); and 609.5315, subdivision 5c, clause (3);

(5) managing the request for proposals for grants for comprehensive services, including trauma-informed, culturally specific services;

(6) identifying best practices in serving sexually exploited youth, as defined in section 260C.007, subdivision 31;

(7) providing oversight of and technical support to regional navigators pursuant to section 145.4717;

(8) conducting a comprehensive evaluation of the statewide program for safe harbor of sexually exploited youth; and

(9) developing a policy consistent with the requirements of chapter 13 for sharing data related to sexually exploited youth, as defined in section 260C.007, subdivision 31, among regional navigators and community-based advocates.

Sec. 37. **[256B.7651] PRESCRIBED PEDIATRIC EXTENDED CARE CENTERS.**

The commissioner shall set payment rates for services provided at prescribed pediatric extended care centers licensed under chapter 144H in one-hour increments, at a rate equal to 85 percent of the payment rate for one hour of complex home care nursing services. The payment rate shall include services provided by nursing staff and direct care staff specified in section 144H.11.

Sec. 38. Minnesota Statutes 2016, section 609.5315, subdivision 5c, is amended to read:

Subd. 5c. **Disposition of money; prostitution.** Money forfeited under section 609.5312, subdivision 1, paragraph (b), must be distributed as follows:

(1) 40 percent must be forwarded to the appropriate agency for deposit as a supplement to the agency's operating fund or similar fund for use in law enforcement;

(2) 20 percent must be forwarded to the prosecuting authority that handled the forfeiture for deposit as a supplement to its operating fund or similar fund for prosecutorial purposes; and

(3) the remaining 40 percent must be forwarded to the commissioner of ~~public safety~~ health to be deposited in the safe harbor for youth account in the special revenue fund and is appropriated to the commissioner for distribution to crime victims services organizations that provide services to sexually exploited youth, as defined in section 260C.007, subdivision 31.

Sec. 39. Minnesota Statutes 2016, section 626.556, subdivision 2, is amended to read:

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

(a) "Accidental" means a sudden, not reasonably foreseeable, and unexpected occurrence or event which:

(1) is not likely to occur and could not have been prevented by exercise of due care; and

(2) if occurring while a child is receiving services from a facility, happens when the facility and the employee or person providing services in the facility are in compliance with the laws and rules relevant to the occurrence or event.

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

(c) "Facility" means:

(1) a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed under sections 144.50 to 144.58, 241.021, or 245A.01 to 245A.16, or chapter 144H or 245D;

(2) a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or

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

(d) "Family assessment" means a comprehensive assessment of child safety, risk of subsequent child maltreatment, and family strengths and needs that is applied to a child maltreatment report that does not allege sexual abuse or substantial child endangerment.

Family assessment does not include a determination as to whether child maltreatment occurred but does determine the need for services to address the safety of family members and the risk of subsequent maltreatment.

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

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

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

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

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

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

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

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

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

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

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

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

(h) "Nonmaltreatment mistake" means:

(1) at the time of the incident, the individual was performing duties identified in the center's child care program plan required under Minnesota Rules, part 9503.0045;

(2) the individual has not been determined responsible for a similar incident that resulted in a finding of maltreatment for at least seven years;

(3) the individual has not been determined to have committed a similar nonmaltreatment mistake under this paragraph for at least four years;

(4) any injury to a child resulting from the incident, if treated, is treated only with remedies that are available over the counter, whether ordered by a medical professional or not; and

(5) except for the period when the incident occurred, the facility and the individual providing services were both in compliance with all licensing requirements relevant to the incident.

This definition only applies to child care centers licensed under Minnesota Rules, chapter 9503. If clauses (1) to (5) apply, rather than making a determination of substantiated maltreatment by the individual, the commissioner of human services shall determine that a nonmaltreatment mistake was made by the individual.

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

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

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

Abuse does not include reasonable and moderate physical discipline of a child administered by a parent or legal guardian which does not result in an injury. Abuse does not include the use of reasonable force by a teacher, principal, or school employee as allowed by section 121A.582. Actions which are not reasonable and moderate include, but are not limited to, any of the following:

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

(2) striking a child with a closed fist;

(3) shaking a child under age three;

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

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

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

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

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

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

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

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

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

(m) "Report" means any communication received by the local welfare agency, police department, county sheriff, or agency responsible for child protection pursuant to this section that describes neglect or physical or sexual abuse of a child and contains sufficient content to identify the child and any person believed to be responsible for the neglect or abuse, if known.

(n) "Sexual abuse" means the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, as defined in section 609.341, or by a person in a position of authority, as defined in section 609.341, subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual conduct in the first degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse also includes any act which involves a minor which constitutes a violation of prostitution offenses under sections 609.321 to 609.324 or 617.246. Effective May 29, 2017, sexual abuse includes all reports of known or suspected child sex trafficking involving a child who is identified as a victim of sex trafficking. Sexual abuse includes child sex trafficking as defined in section 609.321, subdivisions 7a and 7b. Sexual abuse includes threatened sexual abuse which includes the status of a parent or household member who has committed a violation which requires

registration as an offender under section 243.166, subdivision 1b, paragraph (a) or (b), or required registration under section 243.166, subdivision 1b, paragraph (a) or (b).

(o) "Substantial child endangerment" means a person responsible for a child's care, by act or omission, commits or attempts to commit an act against a child under their care that constitutes any of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) committed an act that has resulted in an involuntary termination of parental rights under section 260C.301, or a similar law of another jurisdiction; or

(4) committed an act that has resulted in the involuntary transfer of permanent legal and physical custody of a child to a relative under Minnesota Statutes 2010, section 260C.201, subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a similar law of another jurisdiction.

A child is the subject of a report of threatened injury when the responsible social services agency receives birth match data under paragraph (q) from the Department of Human Services.

(q) Upon receiving data under section 144.225, subdivision 2b, contained in a birth record or recognition of parentage identifying a child who is subject to threatened injury under paragraph (p), the Department of Human Services shall send the data to the responsible social services agency. The data is known as "birth match" data. Unless the responsible social services agency has already begun an investigation or assessment of the report due to the birth of the child or execution of the recognition of parentage and the parent's previous history with child protection, the agency shall accept the birth match data as a report under this section. The agency may use either a family assessment or investigation to determine whether the child is safe. All of the provisions of this section apply. If the child is determined to be safe, the agency shall consult with the county attorney to determine the appropriateness of filing a petition alleging the child is in need of protection or services under section 260C.007, subdivision 6, clause (16), in order to deliver needed services. If the child is determined not to be safe, the agency and the county attorney shall take appropriate action as required under section 260C.503, subdivision 2.

(r) Persons who conduct assessments or investigations under this section shall take into account accepted child-rearing practices of the culture in which a child participates and accepted teacher discipline practices, which are not injurious to the child's health, welfare, and safety.

Sec. 40. Minnesota Statutes 2016, section 626.556, subdivision 3, is amended to read:

Subd. 3. **Persons mandated to report; persons voluntarily reporting.** (a) A person who knows or has reason to believe a child is being neglected or physically or sexually abused, as defined in subdivision 2, or has been neglected or physically or sexually abused within the preceding three years, shall immediately report the information to the local welfare agency, agency responsible for assessing or investigating the report, police department, county sheriff, tribal social services agency, or tribal police department if the person is:

(1) a professional or professional's delegate who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, correctional supervision, probation and correctional services, or law enforcement; or

(2) employed as a member of the clergy and received the information while engaged in ministerial duties, provided that a member of the clergy is not required by this subdivision to report information that is otherwise privileged under section 595.02, subdivision 1, paragraph (c).

(b) Any person may voluntarily report to the local welfare agency, agency responsible for assessing or investigating the report, police department, county sheriff, tribal social services agency, or tribal police department if the person knows, has reason to believe, or suspects a child is being or has been neglected or subjected to physical or sexual abuse.

(c) A person mandated to report physical or sexual child abuse or neglect occurring within a licensed facility shall report the information to the agency responsible for licensing the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter 144H or 245D; or a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision ~~19~~ 19a. A health or corrections agency receiving a report may request the local welfare agency to provide assistance pursuant to subdivisions 10, 10a, and 10b. A board or other entity whose licensees perform work within a school facility, upon receiving a complaint of alleged maltreatment, shall provide information about the circumstances of the alleged maltreatment to the commissioner of education. Section 13.03, subdivision 4, applies to data received by the commissioner of education from a licensing entity.

(d) Notification requirements under subdivision 10 apply to all reports received under this section.

(e) For purposes of this section, "immediately" means as soon as possible but in no event longer than 24 hours.

Sec. 41. Minnesota Statutes 2016, section 626.556, subdivision 3c, is amended to read:

Subd. 3c. **Local welfare agency, Department of Human Services or Department of Health responsible for assessing or investigating reports of maltreatment.** (a) The county local welfare agency is the agency responsible for assessing or investigating allegations of maltreatment in child foster care, family child care, legally unlicensed child care, juvenile correctional facilities licensed under section 241.021 located in the local welfare agency's

county, and reports involving children served by an unlicensed personal care provider organization under section 256B.0659. Copies of findings related to personal care provider organizations under section 256B.0659 must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Human Services is the agency responsible for assessing or investigating allegations of maltreatment in facilities licensed under chapters 245A and 245D, except for child foster care and family child care.

(c) The Department of Health is the agency responsible for assessing or investigating allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43 to 144A.482 or chapter 144H.

Sec. 42. Minnesota Statutes 2016, section 626.556, subdivision 10d, is amended to read:

Subd. 10d. **Notification of neglect or abuse in facility.** (a) When a report is received that alleges neglect, physical abuse, sexual abuse, or maltreatment of a child while in the care of a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed according to sections 144.50 to 144.58; 241.021; or 245A.01 to 245A.16; or chapter 144H or 245D, or a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19a, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency investigating the report shall provide the following information to the parent, guardian, or legal custodian of a child alleged to have been neglected, physically abused, sexually abused, or the victim of maltreatment of a child in the facility: the name of the facility; the fact that a report alleging neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility has been received; the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; that the agency is conducting an assessment or investigation; any protective or corrective measures being taken pending the outcome of the investigation; and that a written memorandum will be provided when the investigation is completed.

(b) The commissioner of the agency responsible for assessing or investigating the report or local welfare agency may also provide the information in paragraph (a) to the parent, guardian, or legal custodian of any other child in the facility if the investigative agency knows or has reason to believe the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility has occurred. In determining whether to exercise this authority, the commissioner of the agency responsible for assessing or investigating the

report or local welfare agency shall consider the seriousness of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; the number of children allegedly neglected, physically abused, sexually abused, or victims of maltreatment of a child in the facility; the number of alleged perpetrators; and the length of the investigation. The facility shall be notified whenever this discretion is exercised.

(c) When the commissioner of the agency responsible for assessing or investigating the report or local welfare agency has completed its investigation, every parent, guardian, or legal custodian previously notified of the investigation by the commissioner or local welfare agency shall be provided with the following information in a written memorandum: the name of the facility investigated; the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; the investigator's name; a summary of the investigation findings; a statement whether maltreatment was found; and the protective or corrective measures that are being or will be taken. The memorandum shall be written in a manner that protects the identity of the reporter and the child and shall not contain the name, or to the extent possible, reveal the identity of the alleged perpetrator or of those interviewed during the investigation. If maltreatment is determined to exist, the commissioner or local welfare agency shall also provide the written memorandum to the parent, guardian, or legal custodian of each child in the facility who had contact with the individual responsible for the maltreatment. When the facility is the responsible party for maltreatment, the commissioner or local welfare agency shall also provide the written memorandum to the parent, guardian, or legal custodian of each child who received services in the population of the facility where the maltreatment occurred. This notification must be provided to the parent, guardian, or legal custodian of each child receiving services from the time the maltreatment occurred until either the individual responsible for maltreatment is no longer in contact with a child or children in the facility or the conclusion of the investigation. In the case of maltreatment within a school facility, as defined in section 120A.05, subdivisions 9, 11, and 13, and chapter 124E, the commissioner of education need not provide notification to parents, guardians, or legal custodians of each child in the facility, but shall, within ten days after the investigation is completed, provide written notification to the parent, guardian, or legal custodian of any student alleged to have been maltreated. The commissioner of education may notify the parent, guardian, or legal custodian of any student involved as a witness to alleged maltreatment.

Sec. 43. **BRAIN HEALTH PILOT PROGRAMS.**

Subdivision 1. **Pilot programs selected.** (a) The commissioner shall competitively award grants for up to five pilot programs to improve brain health in youth sports in

Minnesota. The commissioner shall issue a competitive request for pilot program proposals by October 31, 2017, based on input from the youth sports concussion working group. The commissioner shall include members of the working group in the scoring of proposals received, but shall exclude any member of the working group with a financial interest in a pilot program proposal.

(b) Each pilot program selected for a funding award must offer promise for improving at least one of the following areas:

(1) objective identification of brain injury;

(2) assessment and treatment of brain injury;

(3) coordination of school and medical support services; or

(4) policy reform to improve brain health outcomes.

(c) The programs must be selected so that youth are served in each of the following regions of the state:

(1) Central or West Central Minnesota;

(2) Southern, Southwest, or Southeast Minnesota;

(3) Northwest or Northland Minnesota; and

(4) the Twin Cities Metropolitan Area.

Subd. 2. **Funding for pilot programs.** Pilot programs selected under this section shall receive funding for one year beginning January 1, 2018. No later than March 1, 2019, the commissioner must report on the progress and outcomes of the pilot programs to the legislative committees with jurisdiction over health policy and finance.

Sec. 44. **COMPREHENSIVE PLAN TO END HIV/AIDS.**

(a) The commissioner of health, in coordination with the commissioner of human services, and in consultation with community stakeholders, shall develop a strategic statewide comprehensive plan that establishes a set of priorities and actions to address the state's HIV epidemic by reducing the number of newly infected individuals; ensuring that individuals living with HIV have access to quality, life-extending care regardless of race, gender, sexual orientation, or socioeconomic circumstances; and ensuring the coordination of a statewide response to reach the ultimate goal of the elimination of HIV in Minnesota. The commissioner, after consulting with stakeholders, may implement this section utilizing

existing efforts. The commissioner must develop the plan using existing resources available for this purpose.

(b) The plan must identify strategies that are consistent with the National HIV/AIDS Strategy plan, that reflect the scientific developments in HIV medical care and prevention that have occurred, and that work toward the elimination of HIV. The plan must:

(1) determine the appropriate level of testing, care, and services necessary to achieve the goal of the elimination of HIV, beginning with meeting the following outcomes:

(i) reduce the number of new diagnoses by at least 75 percent;

(ii) increase the percentage of individuals living with HIV who know their serostatus to at least 90 percent;

(iii) increase the percentage of individuals living with HIV who are receiving HIV treatment to at least 90 percent; and

(iv) increase the percentage of individuals living with HIV who are virally suppressed to at least 90 percent;

(2) provide recommendations for the optimal allocation and alignment of existing state and federal funding in order to achieve the greatest impact and ensure a coordinated statewide effort; and

(3) provide recommendations for evaluating new and enhanced interventions and an estimate of additional resources needed to provide these interventions.

(c) The commissioner shall submit the comprehensive plan and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2018.

Sec. 45. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; FEDERAL WAIVER AMENDMENTS.**

The commissioner of human services shall submit necessary waiver amendments to the Centers for Medicare and Medicaid Services to add services provided at prescribed pediatric extended care centers licensed under Minnesota Statutes, chapter 144H, to the home and community-based waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49. The commissioner shall submit all necessary waiver amendments by October 1, 2017.

Sec. 46. **EARLY DENTAL DISEASE PREVENTION PILOT PROGRAM.**

(a) The commissioner of health shall develop and implement a pilot program to increase awareness and encourage early preventive dental disease intervention for infants and toddlers. The commissioner shall award grants to five designated communities of color or communities of recent immigrants to participate in the pilot program, with at least two designated communities located outside the seven-county metropolitan area.

(b) The commissioner, in consultation with members of the designated communities, shall distribute or cause to be distributed the educational materials and information developed under Minnesota Statutes, section 144.061, to expectant and new parents within the designated communities, including but not limited to making the materials available to health care providers, community clinics, WIC sites, and other relevant sites within the designated communities through a variety of communicative means, including oral, visual, audio, and print.

(c) The commissioner shall work with members of each designated community to ensure that the educational materials and information are distributed. The commissioner shall assist the designated community with developing strategies, including outreach through ethnic radio, webcasts, and local cable programs, and incentives to encourage and provide early preventive dental disease intervention and care for infants and toddlers that are geared toward the ethnic groups residing in the designated community.

(d) The commissioner shall develop measurable outcomes, establish a baseline measurement, and evaluate performance within each designated community in order to measure whether the educational materials, information, strategies, and incentives increased the numbers of infants and toddlers receiving early preventive dental disease intervention and care.

(e) By March 15, 2019, the commissioner shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care. The report shall describe:

(1) the details of the program;

(2) the communities designated for the program;

(3) the strategies, including any incentives implemented;

(4) the outcome measures used; and

(5) the results of the evaluation for each designated community.

Sec. 47. **RECOMMENDATIONS FOR SAFETY AND QUALITY IMPROVEMENT PRACTICES FOR LONG-TERM CARE SERVICES AND SUPPORTS.**

The commissioner of health shall consult with interested stakeholders to explore and make recommendations on how to apply proven safety and quality improvement practices and infrastructure to long-term care services and supports. Interested stakeholders with whom the commissioner must consult shall include but are not limited to representatives of the Minnesota Alliance for Patient Safety partner organizations, the Office of Ombudsman for Long-Term Care, the Minnesota Elder Justice Center, providers of older adult services, the Department of Health, and the Department of Human Services, and experts in the field of long-term care safety and quality improvement. The recommendations shall include mechanisms to apply a patient safety model to the senior care sector, including a system for reporting adverse health events, education and prevention activities, and interim actions to improve systems for processing reports and complaints submitted to the Office of Health Facility Complaints. By January 15, 2018, the commissioner shall submit the recommendations developed under this section, along with draft legislation to implement the recommendations, to the chairs and ranking minority members of the legislative committees with jurisdiction over long-term care.

Sec. 48. **SAFE HARBOR FOR ALL; STATEWIDE SEX TRAFFICKING VICTIMS STRATEGIC PLAN.**

(a) By October 1, 2018, the commissioner of health, in consultation with the commissioners of public safety and human services, shall adopt a comprehensive strategic plan to address the needs of sex trafficking victims statewide.

(b) The commissioner of health shall issue a request for proposals to select an organization to develop the comprehensive strategic plan. The selected organization shall seek recommendations from professionals, community members, and stakeholders from across the state, with an emphasis on the communities most impacted by sex trafficking. At a minimum, the selected organization must seek input from the following groups: sex trafficking survivors and their family members, statewide crime victim services coalitions, victim services providers, nonprofit organizations, task forces, prosecutors, public defenders, tribal governments, public safety and corrections professionals, public health professionals, human services professionals, and impacted community members. The strategic plan shall include recommendations regarding the expansion of Minnesota's Safe Harbor Law to adult victims of sex trafficking.

(c) By January 15, 2019, the commissioner of health shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services and criminal justice finance and policy on developing the statewide strategic plan, including recommendations for additional legislation and funding.

(d) As used in this section, "sex trafficking victim" has the meaning given in Minnesota Statutes, section 609.321, subdivision 7b.

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

Sec. 49. **STUDY AND REPORT ON HOME CARE NURSING WORKFORCE SHORTAGE.**

(a) The chair and ranking minority member of the senate Human Services Reform Finance and Policy Committee and the chair and ranking minority member of the house of representatives Health and Human Services Finance Committee shall convene a working group to study and report on the shortage of registered nurses and licensed practical nurses available to provide low-complexity regular home care services to clients in need of such services, especially clients covered by medical assistance, and to provide recommendations for ways to address the workforce shortage. The working group shall consist of 14 members appointed as follows:

(1) the chair of the senate Human Services Reform Finance and Policy Committee or a designee;

(2) the ranking minority member of the senate Human Services Reform Finance and Policy Committee or a designee;

(3) the chair of the house of representatives Health and Human Services Finance Committee or a designee;

(4) the ranking minority member of the house of representatives Health and Human Services Finance Committee or a designee;

(5) the commissioner of human services or a designee;

(6) the commissioner of health or a designee;

(7) one representative appointed by the Professional Home Care Coalition;

(8) one representative appointed by the Minnesota Home Care Association;

(9) one representative appointed by the Minnesota Board of Nursing;

(10) one representative appointed by the Minnesota Nurses Association;

(11) one representative appointed by the Minnesota Licensed Practical Nurses Association;

(12) one representative appointed by the Minnesota Society of Medical Assistants;

(13) one client who receives regular home care nursing services and is covered by medical assistance appointed by the commissioner of human services after consulting with the appointing authorities identified in clauses (7) to (12); and

(14) one county public health nurse who is a certified assessor appointed by the commissioner of health after consulting with the Minnesota Home Care Association.

(b) The appointing authorities must appoint members by August 1, 2017.

(c) The convening authorities shall convene the first meeting of the working group no later than August 15, 2017, and caucus staff shall provide support and meeting space for the working group. The Department of Health and the Department of Human Services shall provide technical assistance to the working group by providing existing data and analysis documenting the current and projected workforce shortages in the area of regular home care nursing. The home care and assisted living program advisory council established under Minnesota Statutes, section 144A.4799, shall provide advice and recommendations to the working group. Working group members shall serve without compensation and shall not be reimbursed for expenses.

(d) The working group shall:

(1) quantify the number of low-complexity regular home care nursing hours that are authorized but not provided to clients covered by medical assistance, due to the shortage of registered nurses and licensed practical nurses available to provide these home care services;

(2) quantify the current and projected workforce shortages of registered nurses and licensed practical nurses available to provide low-complexity regular home care nursing services to clients, especially clients covered by medical assistance;

(3) develop recommendations for actions to take in the next two years to address the regular home care nursing workforce shortage, including identifying other health care professionals who may be able to provide low-complexity regular home care nursing services with additional training; what additional training may be necessary for these health care professionals; and how to address scope of practice and licensing issues;

(4) compile reimbursement rates for regular home care nursing from other states and determine Minnesota's national ranking with respect to reimbursement for regular home care nursing;

(5) determine whether reimbursement rates for regular home care nursing fully reimburse providers for the cost of providing the service and whether the discrepancy, if any, between rates and costs contributes to lack of access to regular home care nursing; and

(6) by January 15, 2018, report on the findings and recommendations of the working group to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance. The working group's report shall include draft legislation.

(e) The working group shall elect a chair from among its members at its first meeting.

(f) The meetings of the working group shall be open to the public.

(g) This section expires January 16, 2018, or the day after submitting the report required by this section, whichever is earlier.

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

Sec. 50. **YOUTH SPORTS CONCUSSION WORKING GROUP.**

Subdivision 1. **Working group established; duties and membership.** (a) The commissioner of health shall convene a youth sports concussion working group of up to 30 members to:

(1) develop the report described in subdivision 4 to assess the causes and incidence of brain injury in Minnesota youth sports; and

(2) evaluate the implementation of Minnesota Statutes, sections 121A.37 and 121A.38, regarding concussions in youth athletic activity, and best practices for preventing, identifying, evaluating, and treating brain injury in youth sports.

(b) In forming the working group, the commissioner shall solicit nominees from individuals with expertise and experience in the areas of traumatic brain injury in youth and sports, neuroscience, law and policy related to brain health, public health, neurotrauma, provision of care to brain injured youth, and related fields. In selecting members of the working group, the commissioner shall ensure geographic and professional diversity. The working group shall elect a chair from among its members. The commissioner shall be responsible for organizing meetings and preparing a draft report. Members of the working group shall not receive monetary compensation for their participation in the group.

Subd. 2. **Working group goals defined.** The working group shall, at a minimum:

(1) gather and analyze available data on:

(i) the prevalence and causes of youth sports-related concussions including, where possible, data on the number of officials and coaches receiving concussion training;

(ii) the number of coaches, officials, youth athletes, and parents or guardians receiving information about the nature and risks of concussions;

(iii) the number of youth athletes removed from play and the nature and duration of treatment before return to play; and

(iv) policies and procedures related to return to learn in the classroom;

(2) review the rules associated with relevant youth athletic activities and the concussion education policies currently employed;

(3) identify innovative pilot projects in areas such as:

(i) objectively defining and measuring concussions;

(ii) rule changes designed to promote brain health;

(iii) use of technology to identify and treat concussions;

(iv) recognition of cumulative subconcussive effects; and

(v) postconcussion treatment, and return to learn protocols; and

(4) identify regulatory and legal barriers and burdens to achieving better brain health outcomes.

Subd. 3. **Voluntary participation; no new reporting requirements created.** Participation in the working group study by schools, school districts, school governing bodies, parents, athletes, and related individuals and organizations shall be voluntary, and this study shall create no new reporting requirements by schools, school districts, school governing bodies, parents, athletes, and related individuals and organizations.

Subd. 4. **Report.** By December 31, 2018, the youth sports concussion working group shall provide an interim report, and by December 31, 2019, the working group shall provide a final report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and education with recommendations and proposals for a Minnesota model for reducing brain injury in youth sports. The report shall make recommendations regarding:

(1) best practices for reducing and preventing concussions in youth sports;

(2) best practices for schools to employ in order to identify and respond to occurrences of concussions, including return to play and return to learn;

(3) opportunities to highlight and strengthen best practices with external grant support;

(4) opportunities to leverage Minnesota's strengths in brain science research and clinical care for brain injury; and

(5) proposals to develop an innovative Minnesota model for identifying, evaluating, and treating youth sports concussions.

Subd. 5. **Sunset.** The working group expires the day after submitting the report required under subdivision 4, or January 15, 2020, whichever is earlier.

Sec. 51. **REPEALER.**

Minnesota Statutes 2016, section 144.4961, is repealed the day following final enactment.

ARTICLE 4

CHILDREN AND FAMILIES

Section 1. Minnesota Statutes 2016, section 119B.011, is amended by adding a subdivision to read:

Subd. 12a. **Enforcement authority.** "Enforcement authority" means a government agency or department within or outside Minnesota with jurisdiction to investigate or bring a civil or criminal action against a child care provider, including a county, city, or district attorney's office, the Office of the Attorney General, a human services agency, a United States attorney's office, or a law enforcement agency.

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

Sec. 2. Minnesota Statutes 2016, section 119B.011, is amended by adding a subdivision to read:

Subd. 19c. **Stop payment.** "Stop payment" means canceling a payment that was already issued to a provider.

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

Sec. 3. Minnesota Statutes 2016, section 119B.02, subdivision 5, is amended to read:

Subd. 5. **Program integrity.** For child care assistance programs under this chapter, the commissioner shall enforce the requirements for program integrity and fraud prevention investigations under sections 256.046, 256.98, and 256.983 and chapter 245E.

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

Sec. 4. Minnesota Statutes 2016, section 119B.03, subdivision 4, is amended to read:

Subd. 4. **Funding priority.** (a) First priority for child care assistance under the basic sliding fee program must be given to eligible non-MFIP families who do not have a high school or general equivalency diploma or who need remedial and basic skill courses in order to pursue employment or to pursue education leading to employment and who need child care assistance to participate in the education program. This includes student parents as defined under section 119B.011, subdivision 19b. Within this priority, the following subpriorities must be used:

(1) child care needs of minor parents;

(2) child care needs of parents under 21 years of age; and

(3) child care needs of other parents within the priority group described in this paragraph.

(b) Second priority must be given to ~~parents who have completed their MFIP or DWP transition year, or parents who are no longer receiving or eligible for diversionary work program supports.~~

~~(c) Third priority must be given to~~ families who are eligible for portable basic sliding fee assistance through the portability pool under subdivision 9.

~~(d) Fourth~~ (c) Third priority must be given to families in which at least one parent is a veteran as defined under section 197.447.

(d) Fourth priority must be given to eligible families who do not meet the specifications of paragraph (a), (b), (c), or (e).

(e) Fifth priority must be given to eligible families receiving services under section 119B.011, subdivision 20a, if the parents have completed their MFIP or DWP transition year, or the parents are no longer receiving or eligible for DWP supports.

~~(e)~~ (f) Families under paragraph ~~(b)~~ (e) must be added to the basic sliding fee waiting list on the date they begin the transition year under section 119B.011, subdivision 20~~, and~~

~~must be moved into the basic sliding fee program as soon as possible after they complete their transition year~~.

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

Sec. 5. Minnesota Statutes 2016, section 119B.03, subdivision 6, is amended to read:

Subd. 6. **Allocation formula.** The allocation component of basic sliding fee state and federal funds shall be allocated on a calendar year basis. Funds shall be allocated first in amounts equal to each county's guaranteed floor according to subdivision 8, with any remaining available funds allocated according to the following formula:

(a) One-fourth of the funds shall be allocated in proportion to each county's total expenditures for the basic sliding fee child care program reported during the most recent fiscal year completed at the time of the notice of allocation.

(b) Up to one-fourth of the funds shall be allocated in proportion to the number of families participating in the transition year child care program as reported during and averaged over the most recent six months completed at the time of the notice of allocation. Funds in excess of the amount necessary to serve all families in this category shall be allocated according to paragraph ~~(f)~~ (e).

~~(c) Up to one-fourth of the funds shall be allocated in proportion to the average of each county's most recent six months of reported first, second, and third priority waiting list as defined in subdivision 2 and the reinstatement list of those families whose assistance was terminated with the approval of the commissioner under Minnesota Rules, part 3400.0183, subpart 1. Funds in excess of the amount necessary to serve all families in this category shall be allocated according to paragraph (f).~~

~~(d)~~ (c) Up to ~~one-fourth~~ one-half of the funds shall be allocated in proportion to the average of each county's most recent ~~six~~ 12 months of reported waiting list as defined in subdivision 2 and the reinstatement list of those families whose assistance was terminated with the approval of the commissioner under Minnesota Rules, part 3400.0183, subpart 1. Funds in excess of the amount necessary to serve all families in this category shall be allocated according to paragraph ~~(f)~~ (e).

~~(e)~~ (d) The amount necessary to serve all families in paragraphs (b)~~, (c),~~ and ~~(d)~~ (c) shall be calculated based on the basic sliding fee average cost of care per family in the county with the highest cost in the most recently completed calendar year.

~~(f)~~ (e) Funds in excess of the amount necessary to serve all families in paragraphs (b)~~, (c),~~ and ~~(d)~~ (c) shall be allocated in proportion to each county's total expenditures for the

basic sliding fee child care program reported during the most recent fiscal year completed at the time of the notice of allocation.

(f) For calendar year 2018, the initial allocation shall be the average of the final allocation for calendar year 2017 and the amount that would otherwise be the initial allocation using the revised formula for calendar year 2018, adjusted proportionately up or down to match the funds available.

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

Sec. 6. Minnesota Statutes 2016, section 119B.09, subdivision 9a, is amended to read:

Subd. 9a. **Child care centers; assistance.** (a) ~~For the purposes of this subdivision, "qualifying child" means a child who is not a child or dependent of an employee of the child care provider.~~ A child care center may receive authorizations for 25 or fewer children who are dependents of the center's employees. If a child care center is authorized for more than 25 children who are dependents of center employees, the county cannot authorize additional dependents of an employee until the number of children falls below 25.

~~(b) Funds distributed under this chapter must not be paid for child care services that are provided for a child or dependent of an employee under paragraph (a) unless at all times at least 50 percent of the children for whom the child care provider is providing care are qualifying children under paragraph (a).~~

~~(c) If a child care provider satisfies the requirements for payment under paragraph (b), but the percentage of qualifying children under paragraph (a) for whom the provider is providing care falls below 50 percent, the provider shall have four weeks to raise the percentage of qualifying children for whom the provider is providing care to at least 50 percent before payments to the provider are discontinued for child care services provided for a child who is not a qualifying child.~~

~~(d) This subdivision shall be implemented as follows:~~

~~(1) no later than August 1, 2014, the commissioner shall issue a notice to providers who have been identified as ineligible for funds distributed under this chapter as described in paragraph (b); and~~

~~(2) no later than January 5, 2015, payments to providers who do not comply with paragraph (c) will be discontinued for child care services provided for children who are not qualifying children.~~

~~(e) If a child's authorization for child care assistance is terminated under this subdivision, the county shall send a notice of adverse action to the provider and to the child's parent or guardian, including information on the right to appeal, under Minnesota Rules, part 3400.0185.~~

~~(f)~~ (b) Funds paid to providers during the period of time ~~between the issuance of a notice under paragraph (d), clause (1), and discontinuation of payments under paragraph (d), clause (2),~~ when a center is authorized for more than 25 children who are dependents of center employees must not be treated as overpayments under section 119B.11, subdivision 2a, due to noncompliance with this subdivision.

~~(g)~~ (c) Nothing in this subdivision precludes the commissioner from conducting fraud investigations relating to child care assistance, imposing sanctions, and obtaining monetary recovery as otherwise provided by law.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 7. **[119B.097] AUTHORIZATION WITH A SECONDARY PROVIDER.**

(a) If a child uses any combination of the following providers paid by child care assistance, a parent must choose one primary provider and one secondary provider per child that can be paid by child care assistance:

(1) an individual or child care center licensed under chapter 245A;

(2) an individual or child care center or facility holding a valid child care license issued by another state or tribe; or

(3) a child care center exempt from licensing under section 245A.03.

(b) The amount of child care authorized with the secondary provider cannot exceed 20 hours per two-week service period, per child, and the amount of care paid to a child's secondary provider is limited under section 119B.13, subdivision 1. The total amount of child care authorized with both the primary and secondary provider cannot exceed the amount of child care allowed based on the parents' eligible activity schedule, the child's school schedule, and any other factors relevant to the family's child care needs.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 8. Minnesota Statutes 2016, section 119B.125, subdivision 4, is amended to read:

Subd. 4. **Unsafe care.** A county may deny authorization as a child care provider to any applicant or ~~rescind~~ revoke the authorization of any provider when the county knows or has

reason to believe that the provider is unsafe or that the circumstances of the chosen child care arrangement are unsafe. The county must include the conditions under which a provider or care arrangement will be determined to be unsafe in the county's child care fund plan under section 119B.08, subdivision 3.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 9. Minnesota Statutes 2016, section 119B.125, subdivision 6, is amended to read:

Subd. 6. **Record-keeping requirement.** (a) As a condition of payment, all providers receiving child care assistance payments must keep accurate and legible daily attendance records at the site where services are delivered for children receiving child care assistance and must make those records available immediately to the county or the commissioner upon request. The attendance records must be completed daily and include the date, the first and last name of each child in attendance, and the times when each child is dropped off and picked up. To the extent possible, the times that the child was dropped off to and picked up from the child care provider must be entered by the person dropping off or picking up the child. The daily attendance records must be retained at the site where services are delivered for six years after the date of service.

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

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

(d) The commissioner shall develop criteria to direct a county when the county must establish an attendance overpayment under this subdivision.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 10. Minnesota Statutes 2016, section 119B.13, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

~~(g)~~ (i) Notwithstanding Minnesota Rules, part 3400.0130, subpart 7, maximum registration fees in effect on January 1, 2013, shall remain in effect.

EFFECTIVE DATE. Paragraph (a) is effective July 1, 2018. Paragraphs (d) to (i) are effective April 23, 2018.

Sec. 11. Minnesota Statutes 2016, section 119B.13, subdivision 6, is amended to read:

Subd. 6. **Provider payments.** (a) A provider must bill only for services documented according to section 119B.125, subdivision 6. The provider shall bill for services provided within ten days of the end of the service period. ~~If bills are submitted within ten days of the end of the service period,~~ Payments under the child care fund shall be made within ~~30~~ 21 days of receiving a complete bill from the provider. Counties or the state may establish policies that make payments on a more frequent basis.

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

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

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

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

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

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

(4) the provider is operating after:

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

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

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

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

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

(7) the provider fails to grant access to a county or the commissioner during regular business hours to examine all records necessary to determine the extent of services provided to a child care assistance recipient and the appropriateness of a claim for payment.

(e) If a county or the commissioner finds that a provider violated paragraph (d), clause (1) or (2), a county or the commissioner must deny or revoke the provider's authorization and either pursue a fraud disqualification under section 256.98, subdivision 8, paragraph (c), or refer the case to an enforcement authority. A provider's rights related to an authorization denial or revocation under this paragraph are established in section 119B.161. If a provider's authorization is revoked or denied under this paragraph, the denial or revocation lasts until either:

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

(2) the commissioner decides, based on written evidence or argument submitted under section 119B.161, to authorize the provider.

(f) If a county or the commissioner denies or revokes a provider's authorization under paragraph (d), clause (4), the provider shall not be authorized until the order of suspension or order of revocation against the provider is lifted.

~~(e) For purposes of~~ (g) If a county or the commissioner finds that a provider violated paragraph (d), ~~clauses~~ clause (3), (5), ~~and~~ or (6), the county or the commissioner may

~~withhold~~ revoke or deny the provider's authorization ~~or payment for a period of time not to exceed three months beyond the time the condition has been corrected~~. If a provider's authorization is revoked or denied under this paragraph, the denial or revocation may last up to 90 days from the date a county or the commissioner denies or revokes the provider's authorization.

(h) If a county or the commissioner determines a provider violated paragraph (d), clause (7), a county or the commissioner must deny or revoke the provider's authorization until a county or the commissioner determines whether the records sought comply with this chapter and chapter 245E. The provider's rights related to an authorization denial or revocation under this paragraph are established in section 119B.161.

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

EFFECTIVE DATE. The amendments to paragraph (a) are effective September 25, 2017. The amendments to paragraphs (d) to (i) are effective April 23, 2018.

Sec. 12. Minnesota Statutes 2016, section 119B.16, subdivision 1, is amended to read:

Subdivision 1. **Fair hearing allowed for applicants and recipients.** (a) An applicant or recipient adversely affected by an action of a county agency ~~action~~ or the commissioner may request and receive a fair hearing in accordance with this subdivision and section 256.045.

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

(c) An applicant or recipient does not have a right to a fair hearing if a county agency or the commissioner takes action against a provider.

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

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 13. Minnesota Statutes 2016, section 119B.16, subdivision 1a, is amended to read:

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

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

(b) A provider may request a fair hearing only as specified in this subdivision.

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

(1) denies or revokes a provider's authorization, unless the action entitles the provider to a consolidated contested case hearing under subdivision 3 or an administrative review under section 119B.161;

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

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

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

(5) initiates an administrative fraud disqualification hearing; or

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 14. Minnesota Statutes 2016, section 119B.16, subdivision 1b, is amended to read:

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

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 15. Minnesota Statutes 2016, section 119B.16, is amended by adding a subdivision to read:

Subd. 1c. **Notice to providers.** (a) Before taking an action appealable under subdivision 1a, paragraph (c), a county agency or the commissioner must mail written notice to the provider against whom the action is being taken.

(b) The notice shall state:

(1) the factual basis for the department's determination;

(2) the action the department intends to take;

(3) the dollar amount of the monetary recovery or recoupment, if known; and

(4) the right to appeal the department's proposed action.

(c) A county agency or the commissioner must mail the written notice at least 15 calendar days before the adverse action's effective date.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 16. Minnesota Statutes 2016, section 119B.16, is amended by adding a subdivision to read:

Subd. 3. **Consolidated contested case hearing.** If a county agency or the commissioner denies or revokes a provider's authorization based on a licensing action, the provider may only appeal the denial or revocation in the same contested case proceeding that the provider appeals the licensing action.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 17. Minnesota Statutes 2016, section 119B.16, is amended by adding a subdivision to read:

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

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 18. **[119B.161] ADMINISTRATIVE REVIEW.**

Subdivision 1. **Temporary denial or revocation of authorization.** (a) A provider has the rights listed under this section if:

(1) the provider's authorization was denied or revoked under section 119B.13, subdivision 6, paragraph (d), clause (1), (2), or (7);

(2) the provider's authorization was temporarily suspended under paragraph (b); or

(3) a payment was suspended under chapter 245E.

(b) Unless the commissioner receives a timely and proper request for an appeal, a county's or the commissioner's action is a final department action.

(c) The commissioner may temporarily suspend a provider's authorization without prior notice and opportunity for hearing if the commissioner determines either that there is a credible allegation of fraud for which an investigation is pending under the child care assistance program, or that the suspension is necessary for public safety and the best interests of the child care assistance program. An allegation is considered credible if the allegation has indications of reliability. The commissioner may determine that an allegation is credible, if the commissioner reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

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

(b) The notice must:

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

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

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

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

(c) Notwithstanding Minnesota Rules, part 3400.0185, if a county or the commissioner denies or revokes a provider's authorization under section 119B.13, subdivision 6, paragraph (d), clause (1), (2), or (7); suspends a payment to a provider under chapter 245E; or temporarily suspends a payment to a provider under subdivision 1, a county or the commissioner must send notice of termination to an affected family. The termination sent to an affected family is effective on the date the notice is created.

Subd. 3. **Duration.** If a provider's authorization is denied or revoked under section 119B.13, subdivision 6, paragraph (d), clause (1), (2), or (7); authorization is temporarily suspended under this section; or payment is suspended under chapter 245E, the provider's denial, revocation, temporary suspension, or payment suspension remains in effect until:

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 19. Minnesota Statutes 2016, section 245.814, subdivision 2, is amended to read:

Subd. 2. **Application of coverage.** Coverage shall apply to all foster homes licensed by the Department of Human Services, licensed by a federally recognized tribal government, or established by the juvenile court and certified by the commissioner of corrections pursuant to section 260B.198, subdivision 1, clause (3), item (v), to the extent that the liability is not covered by the provisions of the standard homeowner's or automobile insurance policy. The insurance shall not cover ~~property owned by the individual foster home provider, damage caused intentionally by a person over 12 years of age, or~~ property damage arising out of business pursuits or the operation of any vehicle, machinery, or equipment.

Sec. 20. Minnesota Statutes 2016, section 245.814, subdivision 3, is amended to read:

Subd. 3. **Compensation provisions.** If the commissioner of human services is unable to obtain insurance through ordinary methods for coverage of foster home providers, the appropriation shall be returned to the general fund and the state shall pay claims subject to the following limitations.

(a) Compensation shall be provided only for injuries, damage, or actions set forth in subdivision 1.

(b) Compensation shall be subject to the conditions and exclusions set forth in subdivision 2.

(c) The state shall provide compensation for bodily injury, property damage, or personal injury resulting from the foster home providers activities as a foster home provider while the foster child or adult is in the care, custody, and control of the foster home provider in an amount not to exceed $250,000 for each occurrence.

(d) The state shall provide compensation for damage or destruction of property caused or sustained by a foster child or adult in an amount not to exceed ~~$250~~ $1,000 for each occurrence.

(e) The compensation in paragraphs (c) and (d) is the total obligation for all damages because of each occurrence regardless of the number of claims made in connection with the same occurrence, but compensation applies separately to each foster home. The state shall have no other responsibility to provide compensation for any injury or loss caused or sustained by any foster home provider or foster child or foster adult.

This coverage is extended as a benefit to foster home providers to encourage care of persons who need out-of-home care. Nothing in this section shall be construed to mean that foster home providers are agents or employees of the state nor does the state accept any responsibility for the selection, monitoring, supervision, or control of foster home providers which is exclusively the responsibility of the counties which shall regulate foster home providers in the manner set forth in the rules of the commissioner of human services.

Sec. 21. Minnesota Statutes 2016, section 245A.02, subdivision 2b, is amended to read:

Subd. 2b. **Annual or annually.** With the exception of subdivision 2c, "annual" or "annually" means prior to or within the same month of the subsequent calendar year.

Sec. 22. Minnesota Statutes 2016, section 245A.02, is amended by adding a subdivision to read:

Subd. 2c. **Annual or annually; family child care training requirements.** For the purposes of section 245A.50, subdivisions 1 to 9, "annual" or "annually" means the 12-month period beginning on the license effective date or the annual anniversary of the effective date and ending on the day prior to the annual anniversary of the license effective date.

Sec. 23. Minnesota Statutes 2016, section 245A.04, subdivision 4, is amended to read:

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

(1) an inspection of the physical plant;

(2) an inspection of records and documents;

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

(4) observation of the program in operation.

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

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

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

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

Sec. 24. Minnesota Statutes 2016, section 245A.06, subdivision 8, is amended to read:

Subd. 8. **Requirement to post correction order.** (a) For licensed family child care providers and child care centers, upon receipt of any correction order or order of conditional license issued by the commissioner under this section, and notwithstanding a pending request for reconsideration of the correction order or order of conditional license by the license holder, the license holder shall post the correction order or order of conditional license in a place that is conspicuous to the people receiving services and all visitors to the facility for two years. When the correction order or order of conditional license is accompanied by a maltreatment investigation memorandum prepared under section 626.556 or 626.557, the investigation memoranda must be posted with the correction order or order of conditional license.

(b) If the commissioner reverses or rescinds a violation in a correction order upon reconsideration under subdivision 2, the commissioner shall issue an amended correction order and the license holder shall post the amended order according to paragraph (a).

(c) If the correction order is rescinded or reversed in full upon reconsideration under subdivision 2, the license holder shall remove the original correction order posted according to paragraph (a).

Sec. 25. Minnesota Statutes 2016, section 245A.06, is amended by adding a subdivision to read:

Subd. 9. **Child care correction order quotas prohibited.** The commissioner and county licensing agencies shall not order, mandate, require, or suggest to any person responsible for licensing or inspecting a licensed family child care provider or child care center a quota for the issuance of correction orders on a daily, weekly, monthly, quarterly, or yearly basis.

Sec. 26. **[245A.065] CHILD CARE FIX-IT TICKET.**

(a) In lieu of a correction order under section 245A.06, the commissioner shall issue a fix-it ticket to a family child care or child care center license holder if the commissioner finds that:

(1) the license holder has failed to comply with a requirement in this chapter or Minnesota Rules, chapter 9502 or 9503, that the commissioner determines to be eligible for a fix-it ticket;

(2) the violation does not imminently endanger the health, safety, or rights of the persons served by the program;

(3) the license holder did not receive a fix-it ticket or correction order for the violation at the license holder's last licensing inspection;

(4) the violation can be corrected at the time of inspection or within 48 hours, excluding Saturdays, Sundays, and holidays; and

(5) the license holder corrects the violation at the time of inspection or agrees to correct the violation within 48 hours, excluding Saturdays, Sundays, and holidays.

(b) The fix-it ticket must state:

(1) the conditions that constitute a violation of the law or rule;

(2) the specific law or rule violated; and

(3) that the violation was corrected at the time of inspection or must be corrected within 48 hours, excluding Saturdays, Sundays, and holidays.

(c) The commissioner shall not publicly publish a fix-it ticket on the department's Web site.

(d) Within 48 hours, excluding Saturdays, Sundays, and holidays, of receiving a fix-it ticket, the license holder must correct the violation and within one week submit evidence to the licensing agency that the violation was corrected.

(e) If the violation is not corrected at the time of inspection or within 48 hours, excluding Saturdays, Sundays, and holidays, or the evidence submitted is insufficient to establish that the license holder corrected the violation, the commissioner must issue a correction order for the violation of Minnesota law or rule identified in the fix-it ticket according to section 245A.06.

(f) The commissioner shall, following consultation with family child care license holders, child care center license holders, and county agencies, issue a report by October 1, 2017, that identifies the violations of this chapter and Minnesota Rules, chapters 9502 and 9503, that are eligible for a fix-it ticket. The commissioner shall provide the report to county agencies and the chairs and ranking minority members of the legislative committees with jurisdiction over child care, and shall post the report to the department's Web site.

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

Sec. 27. **[245A.1434] INFORMATION FOR CHILD CARE LICENSE HOLDERS.**

The commissioner shall inform family child care and child care center license holders on a timely basis of changes to state and federal statute, rule, regulation, and policy relating to the provision of licensed child care, the child care assistance program under chapter 119B, the quality rating and improvement system under section 124D.142, and child care licensing functions delegated to counties. Communications under this section shall include information to promote license holder compliance with identified changes. Communications under this section may be accomplished by electronic means and shall be made available to the public online.

Sec. 28. **[245A.153] REPORT TO LEGISLATURE ON THE STATUS OF CHILD CARE.**

Subdivision 1. **Reporting requirements.** Beginning on February 1, 2018, and no later than February 1 of each year thereafter, the commissioner of human services shall provide a report on the status of child care in Minnesota to the chairs and ranking minority members of the legislative committees with jurisdiction over child care.

Subd. 2. **Contents of report.** (a) The report must include the following:

(1) summary data on trends in child care center and family child care capacity and availability throughout the state, including the number of centers and programs that have opened and closed and the geographic locations of those centers and programs;

(2) a description of any changes to statutes, administrative rules, or agency policies and procedures that were implemented in the year preceding the report;

(3) a description of the actions the department has taken to address or implement the recommendations from the Legislative Task Force on Access to Affordable Child Care Report dated January 15, 2017, including but not limited to actions taken in the areas of:

(i) encouraging uniformity in implementing and interpreting statutes, administrative rules, and agency policies and procedures relating to child care licensing and access;

(ii) improving communication with county licensors and child care providers regarding changes to statutes, administrative rules, and agency policies and procedures, ensuring that information is directly and regularly transmitted;

(iii) providing notice to child care providers before issuing correction orders or negative actions relating to recent changes to statutes, administrative rules, and agency policies and procedures;

(iv) implementing confidential, anonymous communication processes for child care providers to ask questions and receive prompt, clear answers from the department;

(v) streamlining processes to reduce duplication or overlap in paperwork and training requirements for child care providers; and

(vi) compiling and distributing information detailing trends in the violations for which correction orders and negative actions are issued;

(4) a description of the department's efforts to cooperate with counties while addressing and implementing the task force recommendations;

(5) summary data on child care assistance programs including but not limited to state funding and numbers of families served; and

(6) summary data on family child care correction orders, including:

(i) the number of licensed family child care provider appeals or requests for reconsideration of correction orders to the Department of Human Services;

(ii) the number of family child care correction order appeals or requests for reconsideration that the Department of Human Services grants; and

(iii) the number of family child care correction order appeals or requests for reconsideration that the Department of Human Services denies.

(b) The commissioner may offer recommendations for legislative action.

Subd. 3. **Sunset.** This section expires February 2, 2020.

Sec. 29. **[245A.23] EXEMPTION FROM POSITIVE SUPPORT STRATEGIES REQUIREMENTS.**

A program licensed as a family day care facility or group family day care facility under Minnesota Rules, chapter 9502, and a program licensed as a child care center under Minnesota Rules, chapter 9503, are exempt from Minnesota Rules, chapter 9544, relating to positive support strategies and restrictive interventions.

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

Sec. 30. Minnesota Statutes 2016, section 245E.01, is amended by adding a subdivision to read:

Subd. 6a. **Credible allegation of fraud.** "Credible allegation of fraud" has the meaning given in section 256B.064, subdivision 2, paragraph (b), clause (2).

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

Sec. 31. Minnesota Statutes 2016, section 245E.02, subdivision 1, is amended to read:

Subdivision 1. **Investigating provider or recipient financial misconduct.** The department shall investigate alleged or suspected financial misconduct by providers and errors related to payments issued by the child care assistance program under this chapter. Recipients, employees, agents and consultants, and staff may be investigated when the evidence shows that their conduct is related to the financial misconduct of a provider, license holder, or controlling individual. When the alleged or suspected financial misconduct relates to acting as a recruiter offering conditional employment on behalf of a provider that has received funds from the child care assistance program, the department may investigate the provider, center owner, director, manager, license holder, or other controlling individual or agent, who is alleged to have acted as a recruiter offering conditional employment.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 32. Minnesota Statutes 2016, section 245E.02, subdivision 3, is amended to read:

Subd. 3. **Determination of investigation.** After completing its investigation, the department shall ~~issue one of the following determinations~~ determine that:

(1) no violation of child care assistance requirements occurred;

(2) there is insufficient evidence to show that a violation of child care assistance requirements occurred;

(3) a preponderance of evidence shows a violation of child care assistance program law, rule, or policy; or

(4) there exists a credible allegation of fraud involving the child care assistance program.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 33. Minnesota Statutes 2016, section 245E.02, subdivision 4, is amended to read:

Subd. 4. ~~**Actions**~~ **Referrals or administrative** ~~**sanctions**~~ **actions.** (a) After completing the determination under subdivision 3, the department may take one or more of the actions or sanctions specified in this subdivision.

(b) The department may take any of the following actions:

(1) refer the investigation to law enforcement or a county attorney for possible criminal prosecution;

(2) refer relevant information to the department's licensing division, the background studies division, the child care assistance program, the Department of Education, the federal child and adult care food program, or appropriate child or adult protection agency;

(3) enter into a settlement agreement with a provider, license holder, owner, agent, controlling individual, or recipient; or

(4) refer the matter for review by a prosecutorial agency with appropriate jurisdiction for possible civil action under the Minnesota False Claims Act, chapter 15C.

(c) In addition to section 256.98, the department may impose sanctions by:

(1) pursuing administrative disqualification through hearings or waivers;

(2) establishing and seeking monetary recovery or recoupment;

(3) issuing an order of corrective action that states the practices that are violations of child care assistance program policies, laws, or regulations, and that they must be corrected; ~~or~~

(4) suspending~~, denying, or terminating~~ payments to a provider~~.~~; or

(5) taking an action under section 119B.13, subdivision 6, paragraph (d).

(d) ~~Upon a finding by~~ If the commissioner determines that any child care provider, center owner, director, manager, license holder, or other controlling individual of a child care

center has employed, used, or acted as a recruiter offering conditional employment for a child care center that has received child care assistance program funding, the commissioner shall:

(1) immediately suspend all program payments to all child care centers in which the person employing, using, or acting as a recruiter offering conditional employment is an owner, director, manager, license holder, or other controlling individual. The commissioner shall suspend program payments under this clause even if services have already been provided; and

(2) immediately and permanently revoke the licenses of all child care centers of which the person employing, using, or acting as a recruiter offering conditional employment is an owner, director, manager, license holder, or other controlling individual.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 34. Minnesota Statutes 2016, section 245E.03, subdivision 2, is amended to read:

Subd. 2. **Failure to provide access.** ~~Failure to provide access may result in denial or termination of authorizations for or payments to a recipient, provider, license holder, or controlling individual in the child care assistance program.~~ If a provider fails to grant the department immediate access to records, the department may immediately suspend payments under section 119B.161, or the department may deny or revoke the provider's authorization. A provider, license holder, controlling individual, employee, or staff member must grant the department access during any hours that the program is open to examine the provider's program or the records listed in section 245E.05. A provider shall make records immediately available at the provider's place of business at the time the department requests access, unless the provider and the department both agree otherwise.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 35. Minnesota Statutes 2016, section 245E.03, subdivision 4, is amended to read:

Subd. 4. **Continued or repeated failure to provide access.** If the provider continues to fail to provide access at the expiration of the 15-day notice period, child care assistance program payments to the provider must be ~~denied~~ suspended beginning the 16th day following notice of the initial failure or refusal to provide access. ~~The department may rescind the denial based upon good cause if the provider submits in writing a good cause basis for having failed or refused to provide access. The writing must be postmarked no later than the 15th day following the provider's notice of initial failure to provide access.~~ A

provider's, license holder's, controlling individual's, employee's, staff member's, or recipient's duty to provide access in this section continues after the provider's authorization is denied, revoked, or suspended. Additionally, the provider, license holder, or controlling individual must immediately provide complete, ongoing access to the department. Repeated failures to provide access must, after the initial failure or for any subsequent failure, result in termination from participation in the child care assistance program.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 36. Minnesota Statutes 2016, section 245E.04, is amended to read:

245E.04 HONEST AND TRUTHFUL STATEMENTS.

It shall be unlawful for a provider, license holder, controlling individual, or recipient to:

(1) falsify, conceal, or cover up by any ~~trick, scheme, or device a material fact~~ means a material fact;

(2) make any materially false, fictitious, or fraudulent statement or representation; or

(3) make or use any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry related to any child care assistance program services that the provider, license holder, or controlling individual supplies or in relation to any child care assistance payments received by a provider, license holder, or controlling individual or to any fraud investigator or law enforcement officer conducting a financial misconduct investigation.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 37. Minnesota Statutes 2016, section 245E.05, subdivision 1, is amended to read:

Subdivision 1. **Records required to be retained.** The following records must be maintained, controlled, and made immediately accessible to license holders, providers, and controlling individuals. The records must be organized and labeled to correspond to categories that make them easy to identify so that they can be made available immediately upon request to an investigator acting on behalf of the commissioner at the provider's place of business:

(1) payroll ledgers, canceled checks, bank deposit slips, and any other accounting records;

(2) daily attendance records required by and that comply with section 119B.125, subdivision 6;

(3) billing transmittal forms requesting payments from the child care assistance program and billing adjustments related to child care assistance program payments;

(4) records identifying all persons, corporations, partnerships, and entities with an ownership or controlling interest in the provider's child care business;

(5) employee or contractor records identifying those persons currently employed by the provider's child care business or who have been employed by the business at any time within the previous five years. The records must include each employee's name, hourly and annual salary, qualifications, position description, job title, and dates of employment. In addition, employee records that must be made available include the employee's time sheets, current home address of the employee or last known address of any former employee, and documentation of background studies required under chapter 119B or 245C;

(6) records related to transportation of children in care, including but not limited to:

(i) the dates and times that transportation is provided to children for transportation to and from the provider's business location for any purpose. For transportation related to field trips or locations away from the provider's business location, the names and addresses of those field trips and locations must also be provided;

(ii) the name, business address, phone number, and Web site address, if any, of the transportation service utilized; and

(iii) all billing or transportation records related to the transportation.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 38. Minnesota Statutes 2016, section 245E.06, subdivision 1, is amended to read:

Subdivision 1. **Factors regarding imposition of administrative ~~sanctions~~ actions.** (a) The department shall consider the following factors in determining the administrative ~~sanctions~~ actions to be imposed:

(1) nature and extent of financial misconduct;

(2) history of financial misconduct;

(3) actions taken or recommended by other state agencies, other divisions of the department, and court and administrative decisions;

(4) prior ~~imposition of sanctions~~ actions;

(5) size and type of provider;

(6) information obtained through an investigation from any source;

(7) convictions or pending criminal charges; and

(8) any other information relevant to the acts or omissions related to the financial misconduct.

(b) Any single factor under paragraph (a) may be determinative of the department's decision of whether and what ~~sanctions are imposed~~ actions to take.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 39. Minnesota Statutes 2016, section 245E.06, subdivision 2, is amended to read:

Subd. 2. **Written notice of department ~~sanction~~ action; ~~sanction~~ action effective date; ~~informal meeting~~.** ~~(a) The department shall give notice in writing to a person of an administrative sanction that is to be imposed. The notice shall be sent by mail as defined in section 245E.01, subdivision 11.~~

~~(b) The notice shall state:~~

~~(1) the factual basis for the department's determination;~~

~~(2) the sanction the department intends to take;~~

~~(3) the dollar amount of the monetary recovery or recoupment, if any;~~

~~(4) how the dollar amount was computed;~~

~~(5) the right to dispute the department's determination and to provide evidence;~~

~~(6) the right to appeal the department's proposed sanction; and~~

~~(7) the option to meet informally with department staff, and to bring additional documentation or information, to resolve the issues.~~

~~(c) In cases of determinations resulting in denial or termination of payments, in addition to the requirements of paragraph (b), the notice must state:~~

~~(1) the length of the denial or termination;~~

~~(2) the requirements and procedures for reinstatement; and~~

~~(3) the provider's right to submit documents and written arguments against the denial or termination of payments for review by the department before the effective date of denial or termination.~~

~~(d) The submission of documents and written argument for review by the department under paragraph (b), clause (5) or (7), or paragraph (c), clause (3), does not stay the deadline for filing an appeal.~~

(a) When taking an action against a provider, the department must give notice to:

(1) the provider as specified in section 119B.16 or 119B.161; and

(2) a family as specified under section 119B.161 or Minnesota Rules, part 3400.0185.

~~(c)~~ (b) Notwithstanding section 245E.03, subdivision 4, and except for a payment suspension or action under section 119B.161, subdivision 1, the effective date of the proposed ~~sanction~~ action under this chapter shall be 30 days after the license holder's, provider's, controlling individual's, or recipient's receipt of the notice, unless timely appealed. If a timely appeal is made, the proposed ~~sanction~~ action shall be delayed pending the final outcome of the appeal. Implementation of a proposed ~~sanction~~ action following the resolution of a timely appeal may be postponed if, in the opinion of the department, the delay of ~~sanction~~ action is necessary to protect the health or safety of children in care. ~~The department may consider the economic hardship of a person in implementing the proposed sanction, but economic hardship shall not be a determinative factor in implementing the proposed sanction.~~

~~(f) Requests for an informal meeting to attempt to resolve issues and requests for appeals must be sent or delivered to the department's Office of Inspector General, Financial Fraud and Abuse Division.~~

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 40. Minnesota Statutes 2016, section 245E.06, subdivision 3, is amended to read:

Subd. 3. **Appeal of department ~~sanction~~ action.** ~~(a) If the department does not pursue a criminal action against a provider, license holder, controlling individual, or recipient for financial misconduct, but the department imposes an administrative sanction under section 245E.02, subdivision 4, paragraph (c), any individual or entity against whom the sanction was imposed may appeal the department's administrative sanction under this section pursuant to section 119B.16 or 256.045 with the additional requirements in clauses (1) to (4). An appeal must specify:~~

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

~~(2) the computation that is believed to be correct, if appropriate;~~

~~(3) the authority in the statute or rule relied upon for each disputed item; and~~

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

~~(b) Notwithstanding section 245E.03, subdivision 4, an appeal is considered timely only if postmarked or received by the department's Appeals Division within 30 days after receiving a notice of department sanction.~~

~~(c) Before the appeal hearing, the department may deny or terminate authorizations or payment to the entity or individual if the department determines that the action is necessary to protect the public welfare or the interests of the child care assistance program.~~

A provider's rights related to an action taken under this chapter are established in sections 119B.16 and 119B.161.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 41. Minnesota Statutes 2016, section 245E.07, subdivision 1, is amended to read:

Subdivision 1. **Grounds for and methods of monetary recovery.** (a) The department may obtain monetary recovery from a provider who has been improperly paid by the child care assistance program, regardless of whether the error was on the part of the provider, the department, or the county and regardless of whether the error was intentional ~~or county error~~. The department does not need to establish a pattern ~~as a precondition of monetary recovery~~ of erroneous or false billing claims, duplicate billing claims, or billing claims based on false statements or financial misconduct.

(b) The department shall obtain monetary recovery from providers by the following means:

(1) permitting voluntary repayment of money, either in lump-sum payment or installment payments;

(2) using any legal collection process;

(3) deducting or withholding program payments; or

(4) utilizing the means set forth in chapter 16D.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 42. Minnesota Statutes 2016, section 256.98, subdivision 8, is amended to read:

Subd. 8. **Disqualification from program.** (a) Any person found to be guilty of wrongfully obtaining assistance by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, in the Minnesota family investment

program and any affiliated program to include the diversionary work program and the work participation cash benefit program, the food stamp or food support program, the general assistance program, the group residential housing program, or the Minnesota supplemental aid program shall be disqualified from that program. In addition, any person disqualified from the Minnesota family investment program shall also be disqualified from the food stamp or food support program. The needs of that individual shall not be taken into consideration in determining the grant level for that assistance unit:

(1) for one year after the first offense;

(2) for two years after the second offense; and

(3) permanently after the third or subsequent offense.

The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved. A disqualification established through hearing or waiver shall result in the disqualification period beginning immediately unless the person has become otherwise ineligible for assistance. If the person is ineligible for assistance, the disqualification period begins when the person again meets the eligibility criteria of the program from which they were disqualified and makes application for that program.

(b) A family receiving assistance through child care assistance programs under chapter 119B with a family member who is found to be guilty of wrongfully obtaining child care assistance by a federal court, state court, or an administrative hearing determination or waiver, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions, is disqualified from child care assistance programs. The disqualifications must be for periods of one year and two years for the first and second offenses, respectively. Subsequent violations must result in permanent disqualification. During the disqualification period, disqualification from any child care program must extend to all child care programs and must be immediately applied.

(c) A provider caring for children receiving assistance through child care assistance programs under chapter 119B is disqualified from receiving payment for child care services

from the child care assistance program under chapter 119B when the provider is found to have wrongfully obtained child care assistance by a federal court, state court, or an administrative hearing determination or waiver under section 256.046, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions. The disqualification must be for a period of ~~one year~~ two years for the first offense ~~and two years for the second offense~~. Any subsequent violation must result in permanent disqualification. The disqualification period must be imposed immediately after a determination is made under this paragraph. During the disqualification period, the provider is disqualified from receiving payment from any child care program under chapter 119B.

(d) Any person found to be guilty of wrongfully obtaining MinnesotaCare for adults without children and upon federal approval, all categories of medical assistance and remaining categories of MinnesotaCare, except for children through age 18, by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, is disqualified from that program. The period of disqualification is one year after the first offense, two years after the second offense, and permanently after the third or subsequent offense. The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved.

EFFECTIVE DATE. This section is effective April 23, 2018.

Sec. 43. Minnesota Statutes 2016, section 256I.04, subdivision 1, is amended to read:

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

(a) The individual is aged, blind, or is over 18 years of age and disabled as determined under the criteria used by the title II program of the Social Security Act, and meets the resource restrictions and standards of section 256P.02, and the individual's countable income

after deducting the (1) exclusions and disregards of the SSI program, (2) the medical assistance personal needs allowance under section 256B.35, and (3) an amount equal to the income actually made available to a community spouse by an elderly waiver participant under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058, subdivision 2, is less than the monthly rate specified in the agency's agreement with the provider of group residential housing in which the individual resides.

(b) The individual meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), clauses (1), (3), (5) to (9), and (14), and paragraph (b), if applicable, and the individual's resources are less than the standards specified by section 256P.02, and the individual's countable income as determined under section 256P.06, less the medical assistance personal needs allowance under section 256B.35 is less than the monthly rate specified in the agency's agreement with the provider of group residential housing in which the individual resides.

(c) The individual receives licensed residential crisis stabilization services under section 256B.0624, subdivision 7, and is receiving medical assistance. The individual may receive concurrent group residential housing payments if receiving licensed residential crisis stabilization services under section 256B.0624, subdivision 7.

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

Sec. 44. Minnesota Statutes 2016, section 256I.04, subdivision 3, is amended to read:

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

(1) for group residential housing establishments licensed under chapter 245D provided the facility is needed to meet the census reduction targets for persons with developmental disabilities at regional treatment centers;

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

(3) notwithstanding the provisions of subdivision 2a, for up to ~~190~~ 226 supportive housing units in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a

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

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

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

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

(7) for a group residential housing provider that operates two ten-bed facilities, one located in Hennepin County and one located in Ramsey County, that provide community

support and 24-hour-a-day supervision to serve the mental health needs of individuals who have chronically lived unsheltered; and

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

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

Sec. 45. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision to read:

Subd. 1p. **Supplementary rate; St. Louis County.** (a) Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2017, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, for a group residential housing provider that:

(1) is located in St. Louis County and has had a group residential housing contract with the county since July 2016;

(2) operates a 35-bed facility;

(3) serves women who are chemically dependent, mentally ill, or both;

(4) provides 24-hour per day supervision;

(5) provides on-site support with skilled professionals, including a licensed practical nurse, registered nurses, peer specialists, and resident counselors; and

(6) provides independent living skills training and assistance with family reunification.

Sec. 46. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision to read:

Subd. 1q. **Supplemental rate; Anoka County.** Notwithstanding the provisions in this section, a county agency shall negotiate a supplemental rate for 42 beds in addition to the rate specified in subdivision 1, not to exceed the maximum rate allowed under subdivision 1a, including any legislatively authorized inflationary adjustments, for a group residential housing provider that is located in Anoka County and provides emergency housing on the former Anoka Regional Treatment Center campus. Notwithstanding any other law or rule to the contrary, Anoka County is not responsible for any additional costs associated with the supplemental rate provided for in this subdivision.

Sec. 47. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision to read:

Subd. 1r. **Supplemental rate; Olmsted County.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2017, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $750 per month, including any legislatively authorized inflationary adjustments, for a group residential housing provider located in Olmsted County that operates long-term residential facilities with a total of 104 beds that serve chemically dependent men and women and provide 24-hour-a-day supervision and other support services.

Sec. 48. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision to read:

Subd. 11. **Transfer of emergency shelter funds.** (a) The commissioner shall make a cost-neutral transfer of funding from the group residential housing fund to county human service agencies for emergency shelter beds removed from the group residential housing census under a biennial plan submitted by the county and approved by the commissioner. The biennial plan is due August 1, beginning August 1, 2017. The plan must describe: (1) anticipated and actual outcomes for persons experiencing homelessness in emergency shelters; (2) improved efficiencies in administration; (3) requirements for individual eligibility; and (4) plans for quality assurance monitoring and quality assurance outcomes. The commissioner shall review the county plan to monitor implementation and outcomes at least biennially, and more frequently if the commissioner deems necessary.

(b) The funding under paragraph (a) may be used for the provision of room and board or supplemental services according to section 256I.03, subdivisions 2 and 8. Providers must

meet the requirements of section 256I.04, subdivisions 2a to 2f. Funding must be allocated annually, and the room and board portion of the allocation shall be adjusted according to the percentage change in the group residential housing room and board rate. The room and board portion of the allocation shall be determined at the time of transfer. The commissioner or county may return beds to the group residential housing fund with 180 days' notice, including financial reconciliation.

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

Sec. 49. Minnesota Statutes 2016, section 256I.06, subdivision 8, is amended to read:

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

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

(c) For an individual who receives licensed residential crisis stabilization services under section 256B.0624, subdivision 7, the amount of group residential housing payment is determined by multiplying the group residential housing rate times the period of time the individual was a resident.

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

Sec. 50. Minnesota Statutes 2016, section 256J.45, subdivision 2, is amended to read:

Subd. 2. **General information.** The MFIP orientation must consist of a presentation that informs caregivers of:

(1) the necessity to obtain immediate employment;

(2) the work incentives under MFIP, including the availability of the federal earned income tax credit and the Minnesota working family tax credit;

(3) the requirement to comply with the employment plan and other requirements of the employment and training services component of MFIP, including a description of the range of work and training activities that are allowable under MFIP to meet the individual needs of participants;

(4) the consequences for failing to comply with the employment plan and other program requirements, and that the county agency may not impose a sanction when failure to comply is due to the unavailability of child care or other circumstances where the participant has good cause under subdivision 3;

(5) the rights, responsibilities, and obligations of participants;

(6) the types and locations of child care services available through the county agency;

(7) the availability and the benefits of the early childhood health and developmental screening under sections 121A.16 to 121A.19; 123B.02, subdivision 16; and 123B.10;

(8) the caregiver's eligibility for transition year child care assistance under section 119B.05;

(9) the availability of all health care programs, including transitional medical assistance;

(10) the caregiver's option to choose an employment and training provider and information about each provider, including but not limited to, services offered, program components, job placement rates, job placement wages, and job retention rates;

(11) the caregiver's option to request approval of an education and training plan according to section 256J.53;

(12) the work study programs available under the higher education system; ~~and~~

(13) information about the 60-month time limit exemptions under the family violence waiver and referral information about shelters and programs for victims of family violence~~.~~; and

(14) information about the income exclusions under section 256P.06, subdivision 2.

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

Sec. 51. **[256N.261] SUPPORT FOR ADOPTIVE, FOSTER, AND KINSHIP FAMILIES.**

Subdivision 1. **Program established.** The commissioner of human services shall design and implement a coordinated program to reduce the need for placement changes or out-of-home placements of children and youth in foster care, adoptive placements, and

permanent physical and legal custody kinship placements, and to improve the functioning and stability of these families. To the extent federal funds are available, the commissioner shall provide the following adoption and foster care-competent services and ensure that placements are trauma informed and child and family centered:

(1) a program providing information, referrals, a parent-to-parent support network, peer support for youth, family activities, respite care, crisis services, educational support, and mental health services for children and youth in adoption, foster care, and kinship placements and adoptive, foster, and kinship families from across Minnesota;

(2) training offered around Minnesota for adoptive and kinship families, and additional training for foster families, and the professionals who serve the families, on the effects of trauma, common disabilities of adopted children and children in foster care, and kinship placements, and challenges in adoption, foster care, and kinship placements; and

(3) periodic evaluation of these services to ensure program effectiveness in preserving and improving the success of adoptive, foster, and kinship placements.

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

(b) "Child and family centered" means individualized services that respond to a child's or youth's strengths, interests, and current developmental stage, including social, cognitive, emotional, physical, cultural, racial, and spiritual needs, and offer support to the entire adoptive, foster, or kinship family.

(c) "Trauma informed" means care that acknowledges the effect trauma has on children and the children's families, modifies services to respond to the effects of trauma, emphasizes skill and strength building rather than symptom management, and focuses on the physical and psychological safety of the child and family.

Sec. 52. Minnesota Statutes 2016, section 256P.06, subdivision 2, is amended to read:

Subd. 2. **Exempted individuals.** (a) The following members of an assistance unit under chapters 119B and 256J are exempt from having their earned income count towards the income of an assistance unit:

(1) children under six years old;

(2) caregivers under 20 years of age enrolled at least half-time in school; and

(3) minors enrolled in school full time.

(b) The following members of an assistance unit are exempt from having their earned and unearned income count toward the income of an assistance unit for 18 consecutive

calendar months, beginning the month following the marriage date, for benefits under chapter 256J if the household income does not exceed 275 percent of the federal poverty guidelines:

(1) a new spouse to a caretaker in an existing assistance unit; and

(2) the spouse designated by a newly married couple, when both spouses were already members of an assistance unit under chapter 256J.

(c) If members of an assistance unit identified in paragraph (b) also receive assistance under section 119B.05, they are exempt from having their earned income count toward the income of the assistance unit if the household income prior to the exemption does not exceed 67 percent of the state median income for recipients under section 119B.05 for 39 consecutive biweekly periods beginning the second biweekly period after the marriage date.

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

Sec. 53. Minnesota Statutes 2016, section 260C.451, subdivision 6, is amended to read:

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

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

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

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

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

(d) A child who left foster care while under guardianship of the commissioner of human services retains eligibility for foster care for placement at any time prior to 21 years of age.

Sec. 54. Minnesota Statutes 2016, section 626.556, subdivision 3c, is amended to read:

Subd. 3c. **Local welfare agency, Department of Human Services or Department of Health responsible for assessing or investigating reports of maltreatment.** (a) The county local welfare agency is the agency responsible for assessing or investigating allegations of maltreatment in child foster care, family child care, legally unlicensed child care, ~~juvenile correctional facilities licensed under section 241.021 located in the local welfare agency's county,~~ and reports involving children served by an unlicensed personal care provider organization under section 256B.0659. Copies of findings related to personal care provider organizations under section 256B.0659 must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Human Services is the agency responsible for assessing or investigating allegations of maltreatment in juvenile correctional facilities licensed by the Department of Corrections under section 241.021 and in facilities licensed under chapters 245A and 245D, except for child foster care and family child care.

(c) The Department of Health is the agency responsible for assessing or investigating allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43 to 144A.482.

Sec. 55. **MOBILE FOOD SHELF GRANTS.**

Subdivision 1. **Grant amount.** Hunger Solutions shall award grants on a priority basis under subdivision 3. A grant to sustain an existing mobile program shall not exceed $25,000. A grant to create a new mobile program shall not exceed $75,000.

Subd. 2. **Application contents.** An applicant for a grant under this section must provide the following information to Hunger Solutions:

(1) the location of the project;

(2) a description of the mobile program, including the program's size and scope;

(3) evidence regarding the unserved or underserved nature of the community in which the project is to be located;

(4) evidence of community support for the project;

(5) the total cost of the project;

(6) the amount of the grant request and how funds will be used;

(7) sources of funding or in-kind contributions for the project that may supplement any grant award;

(8) the applicant's commitment to maintain the mobile program; and

(9) any additional information requested by Hunger Solutions.

Subd. 3. **Awarding grants.** In evaluating applications and awarding grants, Hunger Solutions must give priority to an applicant who:

(1) serves unserved or underserved areas;

(2) creates a new mobile program or expands an existing mobile program;

(3) serves areas where a high level of need is identified;

(4) provides evidence of strong support for the project from residents and other institutions in the community;

(5) leverages funding for the project from other private and public sources; and

(6) commits to maintaining the program on a multiyear basis.

Sec. 56. **MINNESOTA PATHWAYS TO PROSPERITY DAKOTA AND OLMSTED COUNTIES' PILOT PROJECT.**

Subdivision 1. **Authorization.** The commissioners of human services, health, education, Minnesota Housing Finance Agency, and management and budget, and hereinafter, the executive branch team, shall work together with Dakota and Olmsted Counties, and other interested stakeholders, to consider the design of a pilot that tests an alternative financing model for the distribution of publicly funded benefits in Dakota and Olmsted Counties.

Subd. 2. **Pilot project design and goals.** The goals of the pilot project are to reduce the historical separation between the state funds and systems affecting families who are receiving public assistance. The pilot project shall eliminate, where possible, funding restrictions to

allow a more comprehensive approach to the needs of the families in the pilot project, and focus on upstream, prevention-oriented supports and interventions.

Subd. 3. **Executive team work.** When planning a potential pilot project, the executive branch team must consider whether a pilot project participant:

(1) is 26 years of age or younger with a minimum of one child;

(2) voluntarily agrees to participate in the pilot project;

(3) is eligible for, applying for, or receiving public benefits including but not limited to housing assistance, education supports, employment supports, child care, transportation supports, medical assistance, earned income tax credit, or the child care tax credit; and

(4) is enrolled in an education program that is focused on obtaining a career that will likely result in a livable wage.

Sec. 57. **CHILD CARE CORRECTION ORDER POSTING GUIDELINES.**

No later than November 1, 2017, the commissioner shall develop guidelines for posting public licensing data for licensed child care programs. In developing the guidelines, the commissioner shall consult with stakeholders, including licensed child care center providers, family child care providers, and county agencies.

Sec. 58. **DIRECTION TO COMMISSIONER; GROUP RESIDENTIAL HOUSING STUDY.**

Within available appropriations, the commissioner of human services shall study the group residential housing supplementary service rates under Minnesota Statutes, section 256I.05, and make recommendations on the supplementary service rate structure to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance by January 15, 2018.

Sec. 59. **REPEALER.**

(a) Minnesota Statutes 2016, sections 179A.50; 179A.51; 179A.52; and 179A.53, are repealed.

(b) Minnesota Statutes 2016, sections 119B.16, subdivision 2; 245E.03, subdivision 3; and 245E.06, subdivisions 4 and 5, and Minnesota Rules, part 3400.0185, subpart 5, are repealed effective April 23, 2018.

ARTICLE 5

HEALTH OCCUPATIONS

Section 1. **[147.033] PRACTICE OF TELEMEDICINE.**

Subdivision 1. **Definition.** For the purposes of this section, "telemedicine" means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. A communication between a licensed health care provider and a patient that consists solely of an e-mail or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way interactive audio, and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, that facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

Subd. 2. **Physician-patient relationship.** A physician-patient relationship may be established through telemedicine.

Subd. 3. **Standards of practice and conduct.** A physician providing health care services by telemedicine in this state shall be held to the same standards of practice and conduct as provided in this chapter for in-person health care services.

Sec. 2. Minnesota Statutes 2016, section 148.171, subdivision 7b, is amended to read:

Subd. 7b. ~~**Intervention**~~ **Encumbered.** ~~"Intervention" means any act or action, based upon clinical judgment and knowledge that a nurse performs to enhance the health outcome of a patient~~ "Encumbered" means (1) a license that is revoked, suspended, or contains limitations on the full and unrestricted practice of nursing when the revocation, suspension, or limitation is imposed by a state licensing board, or (2) a license that is voluntarily surrendered.

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

Sec. 3. Minnesota Statutes 2016, section 148.171, is amended by adding a subdivision to read:

Subd. 7c. **Intervention.** "Intervention" means any act or action based upon clinical judgment and knowledge that a nurse performs to enhance the health outcome of a patient.

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

Sec. 4. Minnesota Statutes 2016, section 148.211, subdivision 1a, is amended to read:

Subd. 1a. **Advanced practice registered nurse licensure.** (a) ~~Effective January 1, 2015,~~ No advanced practice nurse shall practice as an advanced practice registered nurse unless the advanced practice nurse is licensed by the board under this section.

(b) An applicant for a license to practice as an advanced practice registered nurse (APRN) shall apply to the board in a format prescribed by the board and pay a fee in an amount determined under section 148.243.

(c) To be eligible for licensure an applicant:

(1) must hold a current Minnesota professional nursing license or demonstrate eligibility for licensure as a registered nurse in this state;

(2) must not hold an encumbered license as a registered nurse in any state or territory;

(3)(i) must have completed a graduate level APRN program accredited by a nursing or nursing-related accrediting body that is recognized by the United States Secretary of Education or the Council for Higher Education Accreditation as acceptable to the board. The education must be in one of the four APRN roles for at least one population focus~~;~~. For APRN programs completed on or after January 1, 2016, the program must include at least one graduate-level course in each of the following areas: advanced physiology and pathophysiology; advanced health assessment; and pharmacokinetics and pharmacotherapeutics of all broad categories of agents; or

(ii) must demonstrate compliance with the advanced practice nursing educational requirements that were in effect in Minnesota at the time the applicant completed the advanced practice nursing education program;

(4) must be currently certified by a national certifying body recognized by the board in the APRN role and population foci appropriate to educational preparation;

(5) must report any criminal conviction, nolo contendere plea, Alford plea, or other plea arrangement in lieu of conviction; and

(6) must not have committed any acts or omissions which are grounds for disciplinary action in another jurisdiction or, if these acts have been committed and would be grounds for disciplinary action as set forth in section 148.261, the board has found, after investigation, that sufficient restitution has been made.

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

Sec. 5. Minnesota Statutes 2016, section 148.211, subdivision 1c, is amended to read:

Subd. 1c. **Postgraduate practice.** A nurse practitioner or clinical nurse specialist who qualifies for licensure as an advanced practice registered nurse must practice for at least 2,080 hours, within the context of a collaborative agreement, within a hospital or integrated clinical setting where advanced practice registered nurses and physicians work together to provide patient care. The nurse practitioner or clinical nurse specialist shall submit written evidence to the board with the application, or upon completion of the required collaborative practice experience. For purposes of this subdivision, a collaborative agreement is a mutually agreed upon plan for the overall working relationship between a nurse practitioner or clinical nurse specialist, and one or more physicians licensed under chapter 147 or in another state or United States territory, or one or more advanced practice registered nurses licensed under this section that designates the scope of collaboration necessary to manage the care of patients. The nurse practitioner or clinical nurse specialist, and one of the collaborating physicians or advanced practice registered nurses, must have experience in providing care to patients with the same or similar medical problems.

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

Sec. 6. Minnesota Statutes 2016, section 148.211, subdivision 2, is amended to read:

Subd. 2. **Licensure by endorsement.** ~~(a)~~ The board shall issue a license to practice professional nursing or practical nursing without examination to an applicant who has been duly licensed or registered as a nurse under the laws of another state, territory, or country, if in the opinion of the board the applicant has the qualifications equivalent to the qualifications required in this state as stated in subdivision 1, all other laws not inconsistent with this section, and rules promulgated by the board.

~~(b) Effective January 1, 2015, an applicant for advanced practice registered nurse licensure by endorsement is eligible for licensure if the applicant meets the requirements in paragraph (a) and demonstrates:~~

~~(1) current national certification or recertification in the advanced role and population focus area; and~~

~~(2) compliance with the advanced practice nursing educational requirements that were in effect in Minnesota at the time the advanced practice registered nurse completed the advanced practice nursing education program.~~

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

Sec. 7. Minnesota Statutes 2016, section 148.881, is amended to read:

148.881 DECLARATION OF POLICY.

The practice of psychology in Minnesota affects the public health, safety, and welfare. The regulations in ~~sections 148.88 to 148.98~~ the Minnesota Psychology Practice Act as enforced by the Board of Psychology protect the public ~~from the practice of psychology by unqualified persons and from unethical or unprofessional conduct by persons licensed to practice psychology~~ through licensure and regulation to promote access to safe, ethical, and competent psychological services.

Sec. 8. Minnesota Statutes 2016, section 148.89, is amended to read:

148.89 DEFINITIONS.

Subdivision 1. **Applicability.** For the purposes of sections 148.88 to 148.98, the following terms have the meanings given them.

Subd. 2. **Board of Psychology or board.** "Board of Psychology" or "board" means the board established under section 148.90.

Subd. 2a. **Client.** "Client" means ~~each individual or legal, religious, academic, organizational, business, governmental, or other entity that receives, received, or should have received, or arranged for another individual or entity to receive services from an individual regulated under sections 148.88 to 148.98. Client also means an individual's legally authorized representative, such as a parent or guardian. For the purposes of sections 148.88 to 148.98, "client" may include patient, resident, counselee, evaluatee, and, as limited in the rules of conduct, student, supervisee, or research subject. In the case of dual clients, the licensee or applicant for licensure must be aware of the responsibilities to each client, and of the potential for divergent interests of each client~~ a direct recipient of psychological services within the context of a professional relationship that may include a child, adolescent, adult, couple, family, group, organization, community, or other entity. The client may be the person requesting the psychological services or the direct recipient of the services.

Subd. 2b. **Credentialed.** "Credentialed" means having a license, certificate, charter, registration, or similar authority to practice in an occupation regulated by a governmental board or agency.

Subd. 2c. **Designated supervisor.** "Designated supervisor" means a qualified individual who is ~~designated~~ identified and assigned by the primary supervisor to provide additional supervision and training ~~to a licensed psychological practitioner or~~ to an individual who is

obtaining required predegree supervised professional experience or postdegree supervised psychological employment.

Subd. 2d. **Direct services.** "Direct services" means the delivery of preventive, diagnostic, assessment, or therapeutic intervention services where the primary purpose is to benefit a client who is the direct recipient of the service.

Subd. 2e. **Full-time employment.** "Full-time employment" means a minimum of 35 clock hours per week.

Subd. 3. **Independent practice.** "Independent practice" means the practice of psychology without supervision.

Subd. 3a. **Jurisdiction.** "Jurisdiction" means the United States, United States territories, or Canadian provinces or territories.

Subd. 4. **Licensee.** "Licensee" means a person who is licensed by the board ~~as a licensed psychologist or as a licensed psychological practitioner~~.

Subd. 4a. **Provider or provider of services.** "Provider" or "provider of services" means any individual who is regulated by the board~~, and includes a licensed psychologist, a licensed psychological practitioner, a licensee, or an applicant~~.

Subd. 4b. **Primary supervisor.** "Primary supervisor" means a psychologist licensed in Minnesota or other qualified individual who provides the principal supervision ~~to a licensed psychological practitioner or~~ to an individual who is obtaining required predegree supervised professional experience or postdegree supervised psychological employment.

Subd. 5. **Practice of psychology.** "Practice of psychology" means the observation, description, evaluation, interpretation, ~~or~~ prediction, or modification of human behavior by the application of psychological principles, methods, or procedures for ~~any reason, including to prevent, eliminate, or manage~~ the purpose of preventing, eliminating, evaluating, assessing, or predicting symptomatic, maladaptive, or undesired behavior; applying psychological principles in legal settings; and ~~to enhance~~ enhancing interpersonal relationships, work, life and developmental adjustment, personal and organizational effectiveness, behavioral health, and mental health. The practice of psychology includes, but is not limited to, the following services, regardless of whether the provider receives payment for the services:

(1) psychological research and teaching of psychology subject to the exemptions in section 148.9075;

(2) ~~assessment, including psychological testing and other means of evaluating personal characteristics such as intelligence, personality, abilities, interests, aptitudes, and~~

~~neuropsychological functioning~~ psychological testing and the evaluation or assessment of personal characteristics, such as intelligence, personality, cognitive, physical and emotional abilities, skills, interests, aptitudes, and neuropsychological functioning;

(3) ~~a psychological report, whether written or oral, including testimony of a provider as an expert witness, concerning the characteristics of an individual or entity~~ counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, and behavior analysis and therapy;

~~(4) psychotherapy, including but not limited to, categories such as behavioral, cognitive, emotive, systems, psychophysiological, or insight-oriented therapies; counseling; hypnosis; and diagnosis and treatment of:~~

~~(i) mental and emotional disorder or disability;~~

~~(ii) alcohol and substance dependence or abuse;~~

~~(iii) disorders of habit or conduct;~~

~~(iv) the psychological aspects of physical illness or condition, accident, injury, or disability, including the psychological impact of medications;~~

~~(v) life adjustment issues, including work-related and bereavement issues; and~~

~~(vi) child, family, or relationship issues~~

(4) diagnosis, treatment, and management of mental or emotional disorders or disabilities, substance use disorders, disorders of habit or conduct, and the psychological aspects of physical illness, accident, injury, or disability;

(5) ~~psychoeducational services and treatment~~ psychoeducational evaluation, therapy, and remediation; ~~and~~

(6) consultation ~~and supervision~~ with physicians, other health care professionals, and clients regarding available treatment options, including medication, with respect to the provision of care for a specific client;

(7) provision of direct services to individuals or groups for the purpose of enhancing individual and organizational effectiveness, using psychological principles, methods, and procedures to assess and evaluate individuals on personal characteristics for individual development or behavior change or for making decisions about the individual; and

(8) supervision and consultation related to any of the services described in this subdivision.

Subd. 6. **Telesupervision.** "Telesupervision" means the clinical supervision of psychological services through a synchronous audio and video format where the supervisor is not physically in the same facility as the supervisee.

Sec. 9. Minnesota Statutes 2016, section 148.90, subdivision 1, is amended to read:

Subdivision 1. **Board of Psychology.** (a) The Board of Psychology is created with the powers and duties described in this section. The board has 11 members who consist of:

(1) ~~three~~ four individuals licensed as licensed psychologists who have doctoral degrees in psychology;

(2) two individuals licensed as licensed psychologists who have master's degrees in psychology;

(3) two psychologists, not necessarily licensed, ~~one with a~~ who have doctoral ~~degree~~ degrees in psychology ~~and one with either a doctoral or master's degree in psychology~~ representing different training programs in psychology;

~~(4) one individual licensed or qualified to be licensed as: (i) through December 31, 2010, a licensed psychological practitioner; and (ii) after December 31, 2010, a licensed psychologist;~~ and

~~(5)~~ (4) three public members.

(b) After the date on which fewer than 30 percent of the individuals licensed by the board as licensed psychologists qualify for licensure under section 148.907, subdivision 3, paragraph (b), vacancies filled under paragraph (a), clause (2), shall be filled by an individual with either a master's or doctoral degree in psychology licensed or qualified to be licensed as a licensed psychologist.

(c) After the date on which fewer than 15 percent of the individuals licensed by the board as licensed psychologists qualify for licensure under section 148.907, subdivision 3, paragraph (b), vacancies under paragraph (a), clause (2), shall be filled by an individual with either a master's or doctoral degree in psychology licensed or qualified to be licensed as a licensed psychologist.

Sec. 10. Minnesota Statutes 2016, section 148.90, subdivision 2, is amended to read:

Subd. 2. **Members.** (a) The members of the board shall:

(1) be appointed by the governor;

(2) be residents of the state;

(3) serve for not more than two consecutive terms;

(4) designate the officers of the board; and

(5) administer oaths pertaining to the business of the board.

(b) A public member of the board shall represent the public interest and shall not:

(1) be a psychologist~~, psychological practitioner,~~ or have engaged in the practice of psychology;

(2) be an applicant or former applicant for licensure;

(3) be a member of another health profession and be licensed by a health-related licensing board as defined under section 214.01, subdivision 2; the commissioner of health; or licensed, certified, or registered by another jurisdiction;

(4) be a member of a household that includes a psychologist ~~or psychological practitioner~~; or

(5) have conflicts of interest or the appearance of conflicts with duties as a board member.

Sec. 11. Minnesota Statutes 2016, section 148.905, subdivision 1, is amended to read:

Subdivision 1. **General.** The board shall:

(1) adopt and enforce rules for licensing psychologists ~~and psychological practitioners~~ and for regulating their professional conduct;

(2) adopt and enforce rules of conduct governing the practice of psychology;

(3) adopt and implement rules for examinations which shall be held at least once a year to assess applicants' knowledge and skills. The examinations may be written or oral or both, and may be administered by the board or by institutions or individuals designated by the board~~;~~. Before the adoption and implementation of a new national examination, the board must consider whether the examination:

(i) demonstrates reasonable reliability and external validity;

(ii) is normed on a reasonable representative and diverse national sample; and

(iii) is intended to assess an applicant's education, training, and experience for the purpose of public protection;

(4) issue licenses to individuals qualified under sections 148.907 ~~and 148.908~~, 148.909, 148.915, and 148.916, according to the procedures for licensing in Minnesota Rules;

(5) issue copies of the rules for licensing to all applicants;

(6) establish and maintain annually a register of current licenses;

(7) establish and collect fees for the issuance and renewal of licenses and other services by the board. Fees shall be set to defray the cost of administering the provisions of sections 148.88 to 148.98 including costs for applications, examinations, enforcement, materials, and the operations of the board;

(8) educate the public ~~about~~ on the requirements for ~~licensing of psychologists and of psychological practitioners~~ licenses issued by the board and ~~about~~ on the rules of conduct~~, to~~;

(9) enable the public to file complaints against applicants or licensees who may have violated the Psychology Practice Act; ~~and~~

~~(9)~~ (10) adopt and implement requirements for continuing education; and

(11) establish or approve programs that qualify for professional psychology continuing educational credit. The board may hire consultants, agencies, or professional psychological associations to establish and approve continuing education courses.

Sec. 12. Minnesota Statutes 2016, section 148.907, subdivision 1, is amended to read:

Subdivision 1. **Effective date.** ~~After August 1, 1991,~~ No person shall engage in the independent practice of psychology unless that person is licensed as a licensed psychologist or is exempt under section 148.9075.

Sec. 13. Minnesota Statutes 2016, section 148.907, subdivision 2, is amended to read:

Subd. 2. **Requirements for licensure as licensed psychologist.** To become licensed by the board as a licensed psychologist, an applicant shall comply with the following requirements:

(1) pass an examination in psychology;

(2) pass a professional responsibility examination on the practice of psychology;

(3) pass any other examinations as required by board rules;

(4) pay nonrefundable fees to the board for applications, processing, testing, renewals, and materials;

(5) ~~have~~ attained the age of majority, be of good moral character, and have no unresolved disciplinary action or complaints pending in the state of Minnesota or any other jurisdiction;

(6) ~~have~~ earned a doctoral degree with a major in psychology from a regionally accredited educational institution meeting the standards the board has established by rule; and

(7) ~~have~~ completed at least one full year or the equivalent in part time of postdoctoral supervised psychological employment in no less than 12 months and no more than 60 months. If the postdoctoral supervised psychological employment goes beyond 60 months, the board may grant a variance to this requirement.

Sec. 14. **[148.9075] EXEMPTIONS TO LICENSE REQUIREMENT.**

Subdivision 1. **General.** (a) Nothing in sections 148.88 to 148.98 shall prevent members of other professions or occupations from performing functions for which they are competent and properly authorized by law. The following individuals are exempt from the licensure requirements of the Minnesota Psychology Practice Act, provided they operate in compliance with the stated exemption:

(1) individuals licensed by a health-related licensing board as defined under section 214.01, subdivision 2, or by the commissioner of health;

(2) individuals authorized as mental health practitioners as defined under section 245.462, subdivision 17; and

(3) individuals authorized as mental health professionals under section 245.462, subdivision 18.

(b) Any of these individuals must not hold themselves out to the public by any title or description stating or implying they are licensed to engage in the practice of psychology unless they are licensed under sections 148.88 to 148.98 or are using a title in compliance with section 148.96.

Subd. 2. **Business or industrial organization.** Nothing in sections 148.88 to 148.98 shall prevent the use of psychological techniques by a business or industrial organization for its own personnel purposes or by an employment agency or state vocational rehabilitation agency for the evaluation of the agency's clients prior to a recommendation for employment. However, a representative of an industrial or business firm or corporation may not sell, offer, or provide psychological services as specified in section 148.89, unless the services are performed or supervised by an individual licensed under sections 148.88 to 148.98.

Subd. 3. **School psychologist.** (a) Nothing in sections 148.88 to 148.98 shall be construed to prevent a person who holds a license or certificate issued by the State Board of Teaching in accordance with chapters 122A and 129 from practicing school psychology within the scope of employment if authorized by a board of education or by a private school that meets

the standards prescribed by the State Board of Teaching, or from practicing as a school psychologist within the scope of employment in a program for children with disabilities.

(b) Any person exempted under this subdivision shall not offer psychological services to any other individual, organization, or group for remuneration, monetary or otherwise, unless the person is licensed by the Board of Psychology under sections 148.88 to 148.98.

Subd. 4. **Clergy or religious officials.** Nothing in sections 148.88 to 148.98 shall be construed to prevent recognized religious officials, including ministers, priests, rabbis, imams, Christian Science practitioners, and other persons recognized by the board, from conducting counseling activities that are within the scope of the performance of their regular recognizable religious denomination or sect, as defined in current federal tax regulations, if the religious official does not refer to the official's self as a psychologist and the official remains accountable to the established authority of the religious denomination or sect.

Subd. 5. **Teaching and research.** Nothing in sections 148.88 to 148.98 shall be construed to prevent a person employed in a secondary, postsecondary, or graduate institution from teaching and conducting research in psychology within an educational institution that is recognized by a regional accrediting organization or by a federal, state, county, or local government institution, agency, or research facility, so long as:

(1) the institution, agency, or facility provides appropriate oversight mechanisms to ensure public protections; and

(2) the person is not providing direct clinical services to a client or clients as defined in sections 148.88 to 148.98.

Subd. 6. **Psychologist in disaster or emergency relief.** Nothing in sections 148.88 to 148.98 shall be construed to prevent a psychologist sent to this state for the sole purpose of responding to a disaster or emergency relief effort of the state government, the federal government, the American Red Cross, or other disaster or emergency relief organization as long as the psychologist is not practicing in Minnesota longer than 30 days and the sponsoring organization can certify the psychologist's assignment to this state. The board or its designee, at its discretion, may grant an extension to the 30-day time limitation of this subdivision.

Subd. 7. **Psychological consultant.** A license under sections 148.88 to 148.98 is not required by a nonresident of the state, serving as an expert witness, organizational consultant, presenter, or educator on a limited basis provided the person is appropriately trained, educated, or has been issued a license, certificate, or registration by another jurisdiction.

Subd. 8. **Students.** Nothing in sections 148.88 to 148.98 shall prohibit the practice of psychology under qualified supervision by a practicum psychology student, a predoctoral psychology intern, or an individual who has earned a doctoral degree in psychology and is in the process of completing their postdoctoral supervised psychological employment. A student trainee or intern shall use the titles as required under section 148.96, subdivision 3.

Subd. 9. **Other professions.** Nothing in sections 148.88 to 148.98 shall be construed to authorize a person licensed under sections 148.88 to 148.98 to engage in the practice of any profession regulated under Minnesota law, unless the individual is duly licensed or registered in that profession.

Sec. 15. **[148.9077] RELICENSURE.**

A former licensee may apply to the board for licensure after complying with all laws and rules required for applicants for licensure that were in effect on the date the initial Minnesota license was granted. The former licensee must verify to the board that the former licensee has not engaged in the practice of psychology in this state since the last date of active licensure, except as permitted under statutory licensure exemption, and must submit a fee for relicensure.

Sec. 16. Minnesota Statutes 2016, section 148.9105, subdivision 1, is amended to read:

Subdivision 1. **Application.** Retired providers who are licensed or were formerly licensed to practice psychology in the state according to the Minnesota Psychology Practice Act may apply to the board for psychologist emeritus registration ~~or psychological practitioner emeritus registration~~ if they declare that they are retired from the practice of psychology in Minnesota, have not been the subject of disciplinary action in any jurisdiction, and have no unresolved complaints in any jurisdiction. Retired providers shall complete the necessary forms provided by the board and pay a onetime, nonrefundable fee of $150 at the time of application.

Sec. 17. Minnesota Statutes 2016, section 148.9105, subdivision 4, is amended to read:

Subd. 4. **Documentation of status.** A provider granted emeritus registration shall receive a document certifying that emeritus status has been granted by the board and that the registrant has completed the registrant's active career as a psychologist ~~or psychological practitioner~~ licensed in good standing with the board.

Sec. 18. Minnesota Statutes 2016, section 148.9105, subdivision 5, is amended to read:

Subd. 5. **Representation to public.** In addition to the descriptions allowed in section 148.96, subdivision 3, paragraph (e), former licensees who have been granted emeritus registration may represent themselves as "psychologist emeritus" ~~or "psychological practitioner emeritus,"~~ but shall not represent themselves or allow themselves to be represented to the public as "licensed" or otherwise as current licensees of the board.

Sec. 19. Minnesota Statutes 2016, section 148.916, subdivision 1, is amended to read:

Subdivision 1. **Generally.** ~~If~~ (a) A nonresident of the state of Minnesota~~,~~ who is not seeking licensure in this state~~,~~ and who has been issued a license, certificate, or registration by another jurisdiction to practice psychology ~~at the doctoral level, wishes~~ and who intends to practice in Minnesota for more than ~~seven calendar~~ 30 days~~, the person~~ shall apply to the board for guest licensure~~, provided that~~. The psychologist's practice in Minnesota is limited to no more than nine consecutive months per calendar year. Application under this section shall be made no less than 30 days prior to the expected date of practice in Minnesota and shall be subject to approval by the board or its designee. ~~The board shall charge a nonrefundable fee for guest licensure. The board shall adopt rules to implement this section.~~

(b) To be eligible for licensure under this section, the applicant must:

(1) have a license, certification, or registration to practice psychology from another jurisdiction;

(2) have a doctoral degree in psychology from a regionally accredited institution;

(3) be of good moral character;

(4) have no pending complaints or active disciplinary or corrective actions in any jurisdiction;

(5) pass a professional responsibility examination designated by the board; and

(6) pay a fee to the board.

Sec. 20. Minnesota Statutes 2016, section 148.916, subdivision 1a, is amended to read:

Subd. 1a. **Applicants for licensure.** (a) An applicant who is seeking licensure in this state, and who, at the time of application, is licensed, certified, or registered to practice psychology in another jurisdiction at the doctoral level may apply to the board for guest licensure in order to begin practicing psychology in this state while their application is being

processed if the applicant is of good moral character and has no complaints, corrective, or disciplinary action pending in any jurisdiction.

(b) Application under this ~~section~~ subdivision shall be made no less than 30 days prior to the expected date of practice in this state, and must be made concurrently or after submission of an application for licensure as a licensed psychologist if applicable. Applications under this ~~section~~ subdivision are subject to approval by the board or its designee. The board shall charge a fee for guest licensure under this subdivision.

~~(b) The board shall charge a nonrefundable fee for guest licensure under this subdivision.~~

(c) A guest license issued under this subdivision shall be valid for one year from the date of issuance, or until the board has either issued a license or has denied the applicant's application for licensure, whichever is earlier. Guest licenses issued under this ~~section~~ subdivision may be renewed annually until the board has denied the applicant's application for licensure.

Sec. 21. Minnesota Statutes 2016, section 148.925, is amended to read:

148.925 SUPERVISION.

Subdivision 1. **Supervision.** For the purpose of meeting the requirements of ~~this section~~ the Minnesota Psychology Practice Act, supervision means documented in-person consultation~~, which may include interactive, visual electronic communication, between either: (1) a primary supervisor and a licensed psychological practitioner; or (2) a~~ that employs a collaborative relationship that has both facilitative and evaluative components with the goal of enhancing the professional competence and science, and practice-informed professional work of the supervisee. Supervision may include telesupervision between primary or designated ~~supervisor~~ supervisors and ~~an applicant for licensure as a licensed psychologist~~ the supervisee. The supervision shall be adequate to assure the quality and competence of the activities supervised. Supervisory consultation shall include discussions on the nature and content of the practice of the supervisee, including, but not limited to, a review of a representative sample of psychological services in the supervisee's practice.

Subd. 2. **Postdegree supervised psychological employment.** Postdegree supervised psychological employment means required paid or volunteer work experience and postdegree training of an individual seeking to be licensed as a licensed psychologist that involves the professional oversight by a primary supervisor and satisfies the supervision requirements in ~~subdivisions 3 and 5~~ the Minnesota Psychology Practice Act.

Subd. 3. **Individuals qualified to provide supervision.** ~~(a) Supervision of a master's level applicant for licensure as a licensed psychologist shall be provided by an individual:~~

~~(1) who is a psychologist licensed in Minnesota with competence both in supervision in the practice of psychology and in the activities being supervised;~~

~~(2) who has a doctoral degree with a major in psychology, who is employed by a regionally accredited educational institution or employed by a federal, state, county, or local government institution, agency, or research facility, and who has competence both in supervision in the practice of psychology and in the activities being supervised, provided the supervision is being provided and the activities being supervised occur within that regionally accredited educational institution or federal, state, county, or local government institution, agency, or research facility;~~

~~(3) who is licensed or certified as a psychologist in another jurisdiction and who has competence both in supervision in the practice of psychology and in the activities being supervised; or~~

~~(4) who, in the case of a designated supervisor, is a master's or doctorally prepared mental health professional.~~

~~(b)~~ Supervision of ~~a doctoral level~~ an applicant for licensure as a licensed psychologist shall be provided by an individual:

(1) who is a psychologist licensed in Minnesota with a doctoral degree and competence both in supervision in the practice of psychology and in the activities being supervised;

(2) who has a doctoral degree with a major in psychology, who is employed by a regionally accredited educational institution or is employed by a federal, state, county, or local government institution, agency, or research facility, and who has competence both in supervision in the practice of psychology and in the activities being supervised, provided the supervision is being provided and the activities being supervised occur within that regionally accredited educational institution or federal, state, county, or local government institution, agency, or research facility;

(3) who is licensed or certified as a psychologist in another jurisdiction and who has competence both in supervision in the practice of psychology and in the activities being supervised;

(4) who is a psychologist licensed in Minnesota who was licensed before August 1, 1991, with competence both in supervision in the practice of psychology and in the activities being supervised; or

(5) who, in the case of a designated supervisor, is a master's or doctorally prepared mental health professional.

~~Subd. 4. **Supervisory consultation for a licensed psychological practitioner.** Supervisory consultation between a supervising licensed psychologist and a supervised licensed psychological practitioner shall be at least one hour in duration and shall occur on an individual, in-person basis. A minimum of one hour of supervision per month is required for the initial 20 or fewer hours of psychological services delivered per month. For each additional 20 hours of psychological services delivered per month, an additional hour of supervision per month is required. When more than 20 hours of psychological services are provided in a week, no more than one hour of supervision is required per week.~~

Subd. 5. **Supervisory consultation for an applicant for licensure as a licensed psychologist.** Supervision of an applicant for licensure as a licensed psychologist shall include at least two hours of regularly scheduled in-person consultations per week for full-time employment, one hour of which shall be with the supervisor on an individual basis. The remaining hour may be with a designated supervisor. The board may approve an exception to the weekly supervision requirement for a week when the supervisor was ill or otherwise unable to provide supervision. The board may prorate the two hours per week of supervision for individuals preparing for licensure on a part-time basis. Supervised psychological employment does not qualify for licensure when the supervisory consultation is not adequate as described in subdivision 1, or in the board rules.

Subd. 6. **Supervisee duties.** ~~Individuals~~ Applicants preparing for licensure as a licensed psychologist during their postdegree supervised psychological employment may perform as part of their training any ~~functions~~ of the services specified in section 148.89, subdivision 5, but only under qualified supervision.

~~Subd. 7. **Variance from supervision requirements.** (a) An applicant for licensure as a licensed psychologist who entered supervised employment before August 1, 1991, may request a variance from the board from the supervision requirements in this section in order to continue supervision under the board rules in effect before August 1, 1991.~~

~~(b) After a licensed psychological practitioner has completed two full years, or the equivalent, of supervised post-master's degree employment meeting the requirements of subdivision 5 as it relates to preparation for licensure as a licensed psychologist, the board shall grant a variance from the supervision requirements of subdivision 4 or 5 if the licensed psychological practitioner presents evidence of:~~

~~(1) endorsement for specific areas of competency by the licensed psychologist who provided the two years of supervision;~~

~~(2) employment by a hospital or by a community mental health center or nonprofit mental health clinic or social service agency providing services as a part of the mental health service plan required by the Comprehensive Mental Health Act;~~

~~(3) the employer's acceptance of clinical responsibility for the care provided by the licensed psychological practitioner; and~~

~~(4) a plan for supervision that includes at least one hour of regularly scheduled individual in-person consultations per week for full-time employment. The board may approve an exception to the weekly supervision requirement for a week when the supervisor was ill or otherwise unable to provide supervision.~~

~~(c) Following the granting of a variance under paragraph (b), and completion of two additional full years or the equivalent of supervision and post-master's degree employment meeting the requirements of paragraph (b), the board shall grant a variance to a licensed psychological practitioner who presents evidence of:~~

~~(1) endorsement for specific areas of competency by the licensed psychologist who provided the two years of supervision under paragraph (b);~~

~~(2) employment by a hospital or by a community mental health center or nonprofit mental health clinic or social service agency providing services as a part of the mental health service plan required by the Comprehensive Mental Health Act;~~

~~(3) the employer's acceptance of clinical responsibility for the care provided by the licensed psychological practitioner; and~~

~~(4) a plan for supervision which includes at least one hour of regularly scheduled individual in-person supervision per month.~~

~~(d) The variance allowed under this section must be deemed to have been granted to an individual who previously received a variance under paragraph (b) or (c) and is seeking a new variance because of a change of employment to a different employer or employment setting. The deemed variance continues until the board either grants or denies the variance. An individual who has been denied a variance under this section is entitled to seek reconsideration by the board.~~

Sec. 22. Minnesota Statutes 2016, section 148.96, subdivision 3, is amended to read:

Subd. 3. **Requirements for representations to public.** (a) Unless licensed under sections 148.88 to 148.98, except as provided in paragraphs (b) through (e), persons shall not represent themselves or permit themselves to be represented to the public by:

(1) using any title or description of services incorporating the words "psychology," "psychological," "psychological practitioner," or "psychologist"; or

(2) representing that the person has expert qualifications in an area of psychology.

(b) Psychologically trained individuals who are employed by an educational institution recognized by a regional accrediting organization, by a federal, state, county, or local government institution, agency, or research facility, may represent themselves by the title designated by that organization provided that the title does not indicate that the individual is credentialed by the board.

(c) A psychologically trained individual from an institution described in paragraph (b) may offer lecture services and is exempt from the provisions of this section.

(d) A person who is preparing for the practice of psychology under supervision in accordance with board statutes and rules may be designated as a "psychological intern," "psychology fellow," "psychological trainee," or by other terms clearly describing the person's training status.

(e) Former licensees who are completely retired from the practice of psychology may represent themselves using the descriptions in paragraph (a), clauses (1) and (2), but shall not represent themselves or allow themselves to be represented as current licensees of the board.

~~(f) Nothing in this section shall be construed to prohibit the practice of school psychology by a person licensed in accordance with chapters 122A and 129.~~

Sec. 23. Minnesota Statutes 2016, section 148B.53, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** (a) To be licensed as a licensed professional counselor (LPC), an applicant must provide evidence satisfactory to the board that the applicant:

(1) is at least 18 years of age;

(2) is of good moral character;

(3) has completed a master's or doctoral degree program in counseling or a related field, as determined by the board based on the criteria in paragraph (b), that includes a minimum of 48 semester hours or 72 quarter hours and a supervised field experience of not fewer than 700 hours that is counseling in nature;

(4) has submitted to the board a plan for supervision during the first 2,000 hours of professional practice or has submitted proof of supervised professional practice that is acceptable to the board; and

(5) has demonstrated competence in professional counseling by passing the National Counseling Exam (NCE) administered by the National Board for Certified Counselors, Inc. (NBCC) or an equivalent national examination as determined by the board, and ethical, oral, and situational examinations if prescribed by the board.

(b) The degree described in paragraph (a), clause (3), must be from a counseling program recognized by the Council for Accreditation of Counseling and Related Education Programs (CACREP) or from an institution of higher education that is accredited by a regional accrediting organization recognized by the Council for Higher Education Accreditation (CHEA). Specific academic course content and training must include course work in each of the following subject areas:

(1) the helping relationship, including counseling theory and practice;

(2) human growth and development;

(3) lifestyle and career development;

(4) group dynamics, processes, counseling, and consulting;

(5) assessment and appraisal;

(6) social and cultural foundations, including multicultural issues;

(7) principles of etiology, treatment planning, and prevention of mental and emotional disorders and dysfunctional behavior;

(8) family counseling and therapy;

(9) research and evaluation; and

(10) professional counseling orientation and ethics.

~~(c) To be licensed as a professional counselor, a psychological practitioner licensed under section 148.908 need only show evidence of licensure under that section and is not required to comply with paragraph (a), clauses (1) to (3) and (5), or paragraph (b).~~

~~(d)~~ (c) To be licensed as a professional counselor, a Minnesota licensed psychologist need only show evidence of licensure from the Minnesota Board of Psychology and is not required to comply with paragraph (a) or (b).

Sec. 24. Minnesota Statutes 2016, section 150A.06, subdivision 3, is amended to read:

Subd. 3. **Waiver of examination.** (a) All or any part of the examination for dentists ~~or~~, dental therapists, dental hygienists, or dental assistants, except that pertaining to the law of Minnesota relating to dentistry and the rules of the board, may, at the discretion of the board, be waived for an applicant who presents a certificate of having passed all components of the National Board Dental Examinations or evidence of having maintained an adequate scholastic standing as determined by the board~~, in dental school as to dentists, or dental hygiene school as to dental hygienists~~.

(b) The board shall waive the clinical examination required for licensure for any dentist applicant who is a graduate of a dental school accredited by the Commission on Dental Accreditation, who has passed all components of the National Board Dental Examinations, and who has satisfactorily completed a Minnesota-based postdoctoral general dentistry residency program (GPR) or an advanced education in general dentistry (AEGD) program after January 1, 2004. The postdoctoral program must be accredited by the Commission on Dental Accreditation, be of at least one year's duration, and include an outcome assessment evaluation assessing the resident's competence to practice dentistry. The board may require the applicant to submit any information deemed necessary by the board to determine whether the waiver is applicable.

Sec. 25. Minnesota Statutes 2016, section 150A.06, subdivision 8, is amended to read:

Subd. 8. **Licensure by credentials.** (a) Any dental assistant may, upon application and payment of a fee established by the board, apply for licensure based on an evaluation of the applicant's education, experience, and performance record in lieu of completing a board-approved dental assisting program for expanded functions as defined in rule, and may be interviewed by the board to determine if the applicant:

(1) has graduated from an accredited dental assisting program accredited by the Commission on Dental Accreditation~~, or~~ and is currently certified by the Dental Assisting National Board;

(2) is not subject to any pending or final disciplinary action in another state or Canadian province, or if not currently certified or registered, previously had a certification or

registration in another state or Canadian province in good standing that was not subject to any final or pending disciplinary action at the time of surrender;

(3) is of good moral character and abides by professional ethical conduct requirements;

(4) at board discretion, has passed a board-approved English proficiency test if English is not the applicant's primary language; and

(5) has met all expanded functions curriculum equivalency requirements of a Minnesota board-approved dental assisting program.

(b) The board, at its discretion, may waive specific licensure requirements in paragraph (a).

(c) An applicant who fulfills the conditions of this subdivision and demonstrates the minimum knowledge in dental subjects required for licensure under subdivision 2a must be licensed to practice the applicant's profession.

(d) If the applicant does not demonstrate the minimum knowledge in dental subjects required for licensure under subdivision 2a, the application must be denied. If licensure is denied, the board may notify the applicant of any specific remedy that the applicant could take which, when passed, would qualify the applicant for licensure. A denial does not prohibit the applicant from applying for licensure under subdivision 2a.

(e) A candidate whose application has been denied may appeal the decision to the board according to subdivision 4a.

Sec. 26. Minnesota Statutes 2016, section 150A.10, subdivision 4, is amended to read:

Subd. 4. **Restorative procedures.** (a) Notwithstanding subdivisions 1, 1a, and 2, a licensed dental hygienist or licensed dental assistant may perform the following restorative procedures:

(1) place, contour, and adjust amalgam restorations;

(2) place, contour, and adjust glass ionomer;

(3) adapt and cement stainless steel crowns; and

~~(4) place, contour, and adjust class I and class V supragingival composite restorations where the margins are entirely within the enamel; and~~

~~(5)~~ (4) place, contour, and adjust class I, II, and ~~class~~ V supragingival composite restorations on primary ~~teeth~~ and permanent dentition.

(b) The restorative procedures described in paragraph (a) may be performed only if:

(1) the licensed dental hygienist or licensed dental assistant has completed a board-approved course on the specific procedures;

(2) the board-approved course includes a component that sufficiently prepares the licensed dental hygienist or licensed dental assistant to adjust the occlusion on the newly placed restoration;

(3) a licensed dentist or licensed advanced dental therapist has authorized the procedure to be performed; and

(4) a licensed dentist or licensed advanced dental therapist is available in the clinic while the procedure is being performed.

(c) The dental faculty who teaches the educators of the board-approved courses specified in paragraph (b) must have prior experience teaching these procedures in an accredited dental education program.

Sec. 27. **[181.987] HEALTH CARE PRACTITIONER RESTRICTIVE COVENANTS VOID.**

Subdivision 1. **Health care practitioner.** For the purposes of this section, "health care practitioner" means a physician licensed under chapter 147, a physician assistant licensed under chapter 147A and acting within the authorized scope of practice, or an advanced practice registered nurse licensed under sections 148.171 to 148.285.

Subd. 2. **Health care practitioner restrictive covenants.** Any contract by which a health care practitioner is restrained from engaging in a lawful profession, trade, or business of any kind, within Wabasha County, is to that extent void and unenforceable.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to a contract in effect on, or entered into on or after, that date.

Sec. 28. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall change the headnote of Minnesota Statutes, section 147.0375, to read "LICENSURE OF EMINENT PHYSICIANS."

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

Sec. 29. **REPEALER.**

Minnesota Statutes 2016, sections 147.0375, subdivision 7; 148.211, subdivision 1b; 148.243, subdivision 15; 148.906; 148.907, subdivision 5; 148.908; 148.909, subdivision 7; and 148.96, subdivisions 4 and 5, are repealed.

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

ARTICLE 6

CHEMICAL AND MENTAL HEALTH

Section 1. Minnesota Statutes 2016, section 245.462, subdivision 9, is amended to read:

Subd. 9. **Diagnostic assessment.** (a) "Diagnostic assessment" means a ~~written summary of the history, diagnosis, strengths, vulnerabilities, and general service needs of an adult with a mental illness using diagnostic, interview, and other relevant mental health techniques provided by a mental health professional used in developing an individual treatment plan or individual community support plan~~ standard, extended, or brief diagnostic assessment, or an adult update, and has the meaning given in Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota Rules, part 9505.0372, subpart 1, items A, B, C, and E.

(b) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee, as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:

(1) age;

(2) description of symptoms, including reason for referral;

(3) history of mental health treatment;

(4) cultural influences and their impact on the client; and

(5) mental status examination.

(c) On the basis of the brief components, the professional or clinical trainee must draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem.

(d) Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.

(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible for psychological testing as part of the diagnostic process.

(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction with the diagnostic assessment process, a client is eligible for up to three individual or family psychotherapy sessions or family psychoeducation sessions or a combination of the above sessions not to exceed three.

(g) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item B, subitem (3), unit (a), a brief diagnostic assessment may be used for a client's family who requires a language interpreter to participate in the assessment.

Sec. 2. Minnesota Statutes 2016, section 245.4871, is amended by adding a subdivision to read:

Subd. 11a. **Diagnostic assessment.** (a) "Diagnostic assessment" means a standard, extended, or brief diagnostic assessment, or an adult update, and has the meaning given in Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota Rules, part 9505.0372, subpart 1, items A, B, C, and E.

(b) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee, as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:

(1) age;

(2) description of symptoms, including reason for referral;

(3) history of mental health treatment;

(4) cultural influences and their impact on the client; and

(5) mental status examination.

(c) On the basis of the brief components, the professional or clinical trainee must draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem.

(d) Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.

(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible for psychological testing as part of the diagnostic process.

(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction with the diagnostic assessment process, a client is eligible for up to three individual or family psychotherapy sessions or family psychoeducation sessions or a combination of the above sessions not to exceed three.

(g) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item B, subitem (3), unit (a), a brief diagnostic assessment may be used for a client's family who requires a language interpreter to participate in the assessment.

Sec. 3. Minnesota Statutes 2016, section 245.4876, subdivision 2, is amended to read:

Subd. 2. **Diagnostic assessment.** All residential treatment facilities and acute care hospital inpatient treatment facilities that provide mental health services for children must complete a diagnostic assessment for each of their child clients within five working days of admission. Providers of ~~outpatient and~~ day treatment services for children must complete a diagnostic assessment within five days after the child's second visit or 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available and has been completed within 180 days preceding admission, only updating is necessary. "Updating" means a written summary by a mental health professional of the child's current mental health status and service needs. If the child's mental health status has changed markedly since the child's most recent diagnostic assessment, a new diagnostic assessment is required. Compliance with the provisions of this subdivision does not ensure eligibility for medical assistance reimbursement under chapter 256B.

Sec. 4. Minnesota Statutes 2016, section 245A.03, subdivision 2, is amended to read:

Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

(1) residential or nonresidential programs that are provided to a person by an individual who is related unless the residential program is a child foster care placement made by a local social services agency or a licensed child-placing agency, except as provided in subdivision 2a;

(2) nonresidential programs that are provided by an unrelated individual to persons from a single related family;

(3) residential or nonresidential programs that are provided to adults who do not abuse chemicals or who do not have a chemical dependency, a mental illness, a developmental disability, a functional impairment, or a physical disability;

(4) sheltered workshops or work activity programs that are certified by the commissioner of employment and economic development;

(5) programs operated by a public school for children 33 months or older;

(6) nonresidential programs primarily for children that provide care or supervision for periods of less than three hours a day while the child's parent or legal guardian is in the same building as the nonresidential program or present within another building that is directly contiguous to the building in which the nonresidential program is located;

(7) nursing homes or hospitals licensed by the commissioner of health except as specified under section 245A.02;

(8) board and lodge facilities licensed by the commissioner of health that do not provide children's residential services under Minnesota Rules, chapter 2960, mental health or chemical dependency treatment;

(9) homes providing programs for persons placed by a county or a licensed agency for legal adoption, unless the adoption is not completed within two years;

(10) programs licensed by the commissioner of corrections;

(11) recreation programs for children or adults that are operated or approved by a park and recreation board whose primary purpose is to provide social and recreational activities;

(12) programs operated by a school as defined in section 120A.22, subdivision 4; YMCA as defined in section 315.44; YWCA as defined in section 315.44; or JCC as defined in section 315.51, whose primary purpose is to provide child care or services to school-age children;

(13) Head Start nonresidential programs which operate for less than 45 days in each calendar year;

(14) noncertified boarding care homes unless they provide services for five or more persons whose primary diagnosis is mental illness or a developmental disability;

(15) programs for children such as scouting, boys clubs, girls clubs, and sports and art programs, and nonresidential programs for children provided for a cumulative total of less than 30 days in any 12-month period;

(16) residential programs for persons with mental illness, that are located in hospitals;

(17) the religious instruction of school-age children; Sabbath or Sunday schools; or the congregate care of children by a church, congregation, or religious society during the period used by the church, congregation, or religious society for its regular worship;

(18) camps licensed by the commissioner of health under Minnesota Rules, chapter 4630;

(19) mental health outpatient services for adults with mental illness or children with emotional disturbance;

(20) residential programs serving school-age children whose sole purpose is cultural or educational exchange, until the commissioner adopts appropriate rules;

(21) community support services programs as defined in section 245.462, subdivision 6, and family community support services as defined in section 245.4871, subdivision 17;

(22) the placement of a child by a birth parent or legal guardian in a preadoptive home for purposes of adoption as authorized by section 259.47;

(23) settings registered under chapter 144D which provide home care services licensed by the commissioner of health to fewer than seven adults;

(24) chemical dependency or substance abuse treatment activities of licensed professionals in private practice as defined in Minnesota Rules, part 9530.6405, subpart 15~~, when the treatment activities are not paid for by the consolidated chemical dependency treatment fund~~;

(25) consumer-directed community support service funded under the Medicaid waiver for persons with developmental disabilities when the individual who provided the service is:

(i) the same individual who is the direct payee of these specific waiver funds or paid by a fiscal agent, fiscal intermediary, or employer of record; and

(ii) not otherwise under the control of a residential or nonresidential program that is required to be licensed under this chapter when providing the service;

(26) a program serving only children who are age 33 months or older, that is operated by a nonpublic school, for no more than four hours per day per child, with no more than 20 children at any one time, and that is accredited by:

(i) an accrediting agency that is formally recognized by the commissioner of education as a nonpublic school accrediting organization; or

(ii) an accrediting agency that requires background studies and that receives and investigates complaints about the services provided.

A program that asserts its exemption from licensure under item (ii) shall, upon request from the commissioner, provide the commissioner with documentation from the accrediting agency that verifies: that the accreditation is current; that the accrediting agency investigates complaints about services; and that the accrediting agency's standards require background studies on all people providing direct contact services; ~~or~~

(27) a program operated by a nonprofit organization incorporated in Minnesota or another state that serves youth in kindergarten through grade 12; provides structured, supervised youth development activities; and has learning opportunities take place before or after school, on weekends, or during the summer or other seasonal breaks in the school calendar. A program exempt under this clause is not eligible for child care assistance under chapter 119B. A program exempt under this clause must:

(i) have a director or supervisor on site who is responsible for overseeing written policies relating to the management and control of the daily activities of the program, ensuring the health and safety of program participants, and supervising staff and volunteers;

(ii) have obtained written consent from a parent or legal guardian for each youth participating in activities at the site; and

(iii) have provided written notice to a parent or legal guardian for each youth at the site that the program is not licensed or supervised by the state of Minnesota and is not eligible to receive child care assistance payments~~.~~;

(28) a county that is an eligible vendor under section 254B.05 to provide care coordination and comprehensive assessment services; or

(29) a recovery community organization that is an eligible vendor under section 254B.05 to provide peer recovery support services.

(b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a building in which a nonresidential program is located if it shares a common wall with the

building in which the nonresidential program is located or is attached to that building by skyway, tunnel, atrium, or common roof.

(c) Except for the home and community-based services identified in section 245D.03, subdivision 1, nothing in this chapter shall be construed to require licensure for any services provided and funded according to an approved federal waiver plan where licensure is specifically identified as not being a condition for the services and funding.

Sec. 5. Minnesota Statutes 2016, section 245A.191, is amended to read:

245A.191 PROVIDER ELIGIBILITY FOR PAYMENTS FROM THE CHEMICAL DEPENDENCY CONSOLIDATED TREATMENT FUND.

(a) When a chemical dependency treatment provider licensed under Minnesota Rules, parts 2960.0430 to 2960.0490 or 9530.6405 to 9530.6505, agrees to meet the applicable requirements under section 254B.05, subdivision 5, paragraphs (b), clauses (1) to ~~(4)~~ (8) and ~~(6)~~ (10), (c), and (e), to be eligible for enhanced funding from the chemical dependency consolidated treatment fund, the applicable requirements under section 254B.05 are also licensing requirements that may be monitored for compliance through licensing investigations and licensing inspections.

(b) Noncompliance with the requirements identified under paragraph (a) may result in:

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

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

(3) recovery of payments made for the service;

(4) disenrollment in the public payment program; or

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

Sec. 6. Minnesota Statutes 2016, section 254A.03, subdivision 3, is amended to read:

Subd. 3. **Rules for chemical dependency care.** (a) The commissioner of human services shall establish by rule criteria to be used in determining the appropriate level of chemical dependency care for each recipient of public assistance seeking treatment for alcohol or other drug dependency and abuse problems.

(b) Notwithstanding the criteria in Minnesota Rules, parts 9530.6600 to 9530.6655, upon federal approval of comprehensive assessment as a Medicaid benefit, an eligible vendor of

comprehensive assessments under section 254A.19 may determine and approve the appropriate level of substance use disorder treatment for a recipient of public assistance who is seeking treatment. The commissioner shall develop and implement a utilization review process for publicly funded treatment placements to monitor and review the clinical appropriateness and timeliness of all publicly funded placements in treatment.

(c) The process for determining an individual's financial eligibility for the consolidated chemical dependency treatment fund or determining an individual's enrollment in or eligibility for a publicly subsidized health plan is not affected by the individual's choice to access a comprehensive assessment by a vendor for approval of treatment.

Sec. 7. Minnesota Statutes 2016, section 254A.08, subdivision 2, is amended to read:

Subd. 2. **Program requirements.** For the purpose of this section, a detoxification program means a social rehabilitation program licensed by the commissioner under Minnesota Rules, parts 9530.6510 to 9530.6590, and established for the purpose of facilitating access into care and treatment by detoxifying and evaluating the person and providing entrance into a comprehensive program. Evaluation of the person shall include verification by a professional, after preliminary examination, that the person is intoxicated or has symptoms of chemical dependency and appears to be in imminent danger of harming self or others. A detoxification program shall have available the services of a licensed physician for medical emergencies and routine medical surveillance. A detoxification program licensed by the Department of Human Services to serve both adults and minors at the same site must provide for separate sleeping areas for adults and minors.

Sec. 8. Minnesota Statutes 2016, section 254B.01, is amended by adding a subdivision to read:

Subd. 8. **Recovery community organization.** "Recovery community organization" means an independent organization led and governed by representatives of local communities of recovery. A recovery community organization mobilizes resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery from alcohol and other drug addiction. Recovery community organizations provide peer-based recovery support activities such as training of recovery peers. Recovery community organizations provide mentorship and ongoing support to individuals dealing with a substance use disorder and connect the individuals with resources that can support each individual's recovery. A recovery community organization also promotes a recovery-focused orientation in community education and outreach programming and

organizes recovery-focused policy advocacy activities to foster healthy communities and reduce the stigma of substance use disorders.

Sec. 9. Minnesota Statutes 2016, section 254B.03, subdivision 2, is amended to read:

Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical dependency fund is limited to payments for services other than detoxification services licensed under Minnesota Rules, parts 9530.6405 to 9530.6505, that, if located outside of federally recognized tribal lands, would be required to be licensed by the commissioner as a chemical dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and services other than detoxification provided in another state that would be required to be licensed as a chemical dependency program if the program were in the state. Out of state vendors must also provide the commissioner with assurances that the program complies substantially with state licensing requirements and possesses all licenses and certifications required by the host state to provide chemical dependency treatment. Except for chemical dependency transitional rehabilitation programs, vendors receiving payments from the chemical dependency fund must not require co-payment from a recipient of benefits for services provided under this subdivision. Payment from the chemical dependency fund shall be made for necessary room and board costs provided by vendors certified according to section 254B.05, or in a community hospital licensed by the commissioner of health according to sections 144.50 to 144.56 to a client who is:

(1) determined to meet the criteria for placement in a residential chemical dependency treatment program according to rules adopted under section 254A.03, subdivision 3; and

(2) concurrently receiving a chemical dependency treatment service in a program licensed by the commissioner and reimbursed by the chemical dependency fund.

(b) A county may, from its own resources, provide chemical dependency services for which state payments are not made. A county may elect to use the same invoice procedures and obtain the same state payment services as are used for chemical dependency services for which state payments are made under this section if county payments are made to the state in advance of state payments to vendors. When a county uses the state system for payment, the commissioner shall make monthly billings to the county using the most recent available information to determine the anticipated services for which payments will be made in the coming month. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.

(c) The commissioner shall coordinate chemical dependency services and determine whether there is a need for any proposed expansion of chemical dependency treatment services. The commissioner shall deny vendor certification to any provider that has not received prior approval from the commissioner for the creation of new programs or the expansion of existing program capacity. The commissioner shall consider the provider's capacity to obtain clients from outside the state based on plans, agreements, and previous utilization history, when determining the need for new treatment services.

Sec. 10. Minnesota Statutes 2016, section 254B.05, subdivision 1, is amended to read:

Subdivision 1. **Licensure required.** (a) Programs licensed by the commissioner are eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors, notwithstanding the provisions of section 245A.03. American Indian programs that provide chemical dependency primary treatment, extended care, transitional residence, or outpatient treatment services, and are licensed by tribal government are eligible vendors. Detoxification programs are not eligible vendors. Programs that are not licensed as a chemical dependency residential or nonresidential treatment program by the commissioner or by tribal government or do not meet the requirements of subdivisions 1a and 1b are not eligible vendors.

(b) Upon federal approval, a licensed professional in private practice as defined in Minnesota Rules, part 9530.6405, subpart 15, is an eligible vendor of comprehensive assessments and individual substance use disorder treatment services.

(c) Upon federal approval, a county is an eligible vendor for comprehensive assessment services when the service is provided by a licensed professional in private practice as defined in Minnesota Rules, part 9530.6405, subpart 15. Upon federal approval, a county is an eligible vendor of care coordination services when the service is provided by an individual who meets certification requirements identified by the commissioner.

(d) Upon federal approval, a recovery community organization that meets certification requirements identified by the commissioner is an eligible vendor of peer support services provided one-to-one by an individual in recovery from substance use disorder.

(e) A detoxification program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, is not an eligible vendor. A program that is not licensed as a chemical dependency residential or nonresidential treatment or withdrawal management program by the commissioner or by tribal government or does not meet the requirements of subdivisions 1a and 1b is not an eligible vendor.

Sec. 11. Minnesota Statutes 2016, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for chemical dependency services and service enhancements funded under this chapter.

(b) Eligible chemical dependency treatment services include:

(1) outpatient treatment services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480, or applicable tribal license;

(2) comprehensive assessment services, on July 1, 2018, or upon federal approval, whichever is later;

(3) care coordination services, on July 1, 2018, or upon federal approval, whichever is later;

(4) peer recovery support services, on July 1, 2018, or upon federal approval, whichever is later;

(5) withdrawal management services provided according to chapter 245F, on July 1, 2019, or upon federal approval, whichever is later;

~~(2)~~ (6) medication-assisted therapy services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6500, or applicable tribal license;

~~(3)~~ (7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause ~~(2)~~ (6) and provide nine hours of clinical services each week;

~~(4)~~ (8) high, medium, and low intensity residential treatment services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505, or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

~~(5)~~ (9) hospital-based treatment services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480, or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

~~(6)~~ (10) adolescent treatment programs that are licensed as outpatient treatment programs according to Minnesota Rules, parts 9530.6405 to 9530.6485, or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

~~(7)~~ (11) high-intensity residential treatment services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505, or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor

or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

~~(8)~~ (12) room and board facilities that meet the requirements of subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under Minnesota Rules, part 9530.6490, subpart 4; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific programs as defined in section 254B.01, subdivision 4a, or programs or subprograms serving special populations, if the program or subprogram meets the following requirements:

(i) is designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background;

(ii) is governed with significant input from individuals of that specific background; and

(iii) employs individuals to provide individual or group therapy, at least 50 percent of whom are of that specific background, except when the common social background of the individuals served is a traumatic brain injury or cognitive disability and the program employs treatment staff who have the necessary professional training, as approved by the commissioner, to serve clients with the specific disabilities that the program is designed to serve;

(3) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the

client and the nature and provision of any medical services provided are documented in the client file; and

(4) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

(i) the program meets the co-occurring requirements in Minnesota Rules, part 9530.6495;

(ii) 25 percent of the counseling staff are licensed mental health professionals, as defined in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and licensed mental health professional, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two; and

(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in Minnesota Rules, part 9530.6490.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

(f) Subject to federal approval, chemical dependency services that are otherwise covered as direct face-to-face services may be provided via two-way interactive video. The use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions

that would otherwise apply to direct face-to-face services. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

Sec. 12. Minnesota Statutes 2016, section 254B.12, is amended by adding a subdivision to read:

Subd. 3. **Chemical dependency provider rate increase.** For the chemical dependency services listed in section 254B.05, subdivision 5, and provided on or after July 1, 2017, payment rates shall be increased by three percent over the rates in effect on January 1, 2017, for vendors who meet the requirements of section 254B.05.

Sec. 13. Minnesota Statutes 2016, section 256B.0621, subdivision 10, is amended to read:

Subd. 10. **Payment rates.** The commissioner shall set payment rates for targeted case management under this subdivision. Case managers may bill according to the following criteria:

(1) for relocation targeted case management, case managers may bill for direct case management activities, including face-to-face ~~and~~ contact, telephone ~~contacts~~ contact, and interactive video contact according to section 256B.0924, subdivision 4a, in the lesser of:

(i) 180 days preceding an eligible recipient's discharge from an institution; or

(ii) the limits and conditions which apply to federal Medicaid funding for this service;

(2) for home care targeted case management, case managers may bill for direct case management activities, including face-to-face and telephone contacts; and

(3) billings for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

Sec. 14. Minnesota Statutes 2016, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical

assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative or a contact by interactive video that meets the requirements of subdivision 20b; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact or a contact by interactive video that meets the requirements of subdivision 20b with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must

document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and the county pays no share.

(j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

(k) The commissioner shall set aside a portion of the federal funds earned for county expenditures under this section to repay the special revenue maximization account under section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

(l) Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors shall include the federal earnings, the state share, and the county share.

(m) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

(n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the lesser of:

(1) the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year; or

(2) the limits and conditions which apply to federal Medicaid funding for this service.

(o) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(p) If the recipient is receiving care in a hospital, nursing facility, or residential setting licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week, mental health targeted case management services must actively support identification of community alternatives for the recipient and discharge planning.

Sec. 15. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 20b. **Mental health targeted case management through interactive video.** (a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment if:

(1) the person receiving targeted case management services is residing in:

(i) a hospital;

(ii) a nursing facility; or

(iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging establishment or lodging establishment that provides supportive services or health supervision services according to section 157.17 that is staffed 24 hours a day, seven days a week;

(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian, the case management provider, and the provider operating the setting where the person is residing;

(3) the use of interactive video is approved as part of the person's written personal service or case plan, taking into consideration the person's vulnerability and active personal relationships; and

(4) interactive video is used for up to, but not more than, 50 percent of the minimum required face-to-face contact.

(b) The person receiving targeted case management or the person's legal guardian has the right to choose and consent to the use of interactive video under this subdivision and has the right to refuse the use of interactive video at any time.

(c) The commissioner shall establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of delivering the service via interactive video. The attestation may include that the case management provider has:

(1) written policies and procedures specific to interactive video services that are regularly reviewed and updated;

(2) policies and procedures that adequately address client safety before, during, and after the interactive video services are rendered;

(3) established protocols addressing how and when to discontinue interactive video services; and

(4) established a quality assurance process related to interactive video services.

(d) As a condition of payment, the targeted case management provider must document the following for each occurrence of targeted case management provided by interactive video:

(1) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(2) the basis for determining that interactive video is an appropriate and effective means for delivering the service to the person receiving case management services;

(3) the mode of transmission of the interactive video services and records evidencing that a particular mode of transmission was utilized;

(4) the location of the originating site and the distant site; and

(5) compliance with the criteria attested to by the targeted case management provider as provided in paragraph (c).

Sec. 16. Minnesota Statutes 2016, section 256B.0924, is amended by adding a subdivision to read:

Subd. 4a. **Targeted case management through interactive video.** (a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment under subdivision 6 if:

(1) the person receiving targeted case management services is residing in:

(i) a hospital;

(ii) a nursing facility; or

(iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging establishment or lodging establishment that provides supportive services or health supervision services according to section 157.17 that is staffed 24 hours a day, seven days a week;

(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian, the case management provider, and the provider operating the setting where the person is residing;

(3) the use of interactive video is approved as part of the person's written personal service or case plan; and

(4) interactive video is used for up to, but not more than, 50 percent of the minimum required face-to-face contact.

(b) The person receiving targeted case management or the person's legal guardian has the right to choose and consent to the use of interactive video under this subdivision and has the right to refuse the use of interactive video at any time.

(c) The commissioner shall establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of delivering the service via interactive video. The attestation may include that the case management provider has:

(1) written policies and procedures specific to interactive video services that are regularly reviewed and updated;

(2) policies and procedures that adequately address client safety before, during, and after the interactive video services are rendered;

(3) established protocols addressing how and when to discontinue interactive video services; and

(4) established a quality assurance process related to interactive video services.

(d) As a condition of payment, the targeted case management provider must document the following for each occurrence of targeted case management provided by interactive video:

(1) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(2) the basis for determining that interactive video is an appropriate and effective means for delivering the service to the person receiving case management services;

(3) the mode of transmission of the interactive video services and records evidencing that a particular mode of transmission was utilized;

(4) the location of the originating site and the distant site; and

(5) compliance with the criteria attested to by the targeted case management provider as provided in paragraph (c).

Sec. 17. Minnesota Statutes 2016, section 256B.763, is amended to read:

256B.763 CRITICAL ACCESS MENTAL HEALTH RATE INCREASE.

(a) For services defined in paragraph (b) and rendered on or after July 1, 2007, payment rates shall be increased by 23.7 percent over the rates in effect on January 1, 2006, for:

(1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;

(2) community mental health centers under section 256B.0625, subdivision 5; and

(3) mental health clinics and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870, or hospital outpatient psychiatric departments that are designated as essential community providers under section 62Q.19.

(b) This increase applies to group skills training when provided as a component of children's therapeutic services and support, psychotherapy, medication management, evaluation and management, diagnostic assessment, explanation of findings, psychological testing, neuropsychological services, direction of behavioral aides, and inpatient consultation.

(c) This increase does not apply to rates that are governed by section 256B.0625, subdivision 30, or 256B.761, paragraph (b), other cost-based rates, rates that are negotiated with the county, rates that are established by the federal government, or rates that increased between January 1, 2004, and January 1, 2005.

(d) The commissioner shall adjust rates paid to prepaid health plans under contract with the commissioner to reflect the rate increases provided in paragraphs (a), (e), and (f). The prepaid health plan must pass this rate increase to the providers identified in paragraphs (a), (e), (f), and (g).

(e) Payment rates shall be increased by 23.7 percent over the rates in effect on December 31, 2007, for:

(1) medication education services provided on or after January 1, 2008, by adult rehabilitative mental health services providers certified under section 256B.0623; and

(2) mental health behavioral aide services provided on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943.

(f) For services defined in paragraph (b) and rendered on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943 and not already included in paragraph (a), payment rates shall be increased by 23.7 percent over the rates in effect on December 31, 2007.

(g) Payment rates shall be increased by 2.3 percent over the rates in effect on December 31, 2007, for individual and family skills training provided on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943.

(h) For services described in paragraphs (b), (e), and (g) and rendered on or after July 1, 2017, payment rates for mental health clinics and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870, that are not designated as essential community providers under section 62Q.19 shall be equal to payment rates for mental health clinics and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870, that are designated as essential community providers under section 62Q.19. In order to receive increased payment rates under this paragraph, a provider must demonstrate a commitment to serve low-income and underserved populations by:

(1) charging for services on a sliding-fee schedule based on current poverty income guidelines; and

(2) not restricting access or services because of a client's financial limitation.

Sec. 18. **GRANT PROGRAM; MENTAL HEALTH INNOVATION.**

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

(b) "Community partnership" means a project involving the collaboration of two or more eligible applicants.

(c) "Eligible applicant" means an eligible county, Indian tribe, mental health service provider, hospital, or community partnership. Eligible applicant does not include a state-operated direct care and treatment facility or program under chapter 246.

(d) "Intensive residential treatment services" has the meaning given in section 256B.0622, subdivision 2.

(e) "Metropolitan area" means the seven-county metropolitan area, as defined in section 473.121, subdivision 2.

Subd. 2. **Grants authorized.** The commissioner of human services shall, in consultation with stakeholders, award grants to eligible applicants to plan, establish, or operate programs

to improve accessibility and quality of community-based, outpatient mental health services and reduce the number of clients admitted to regional treatment centers and community behavioral health hospitals. This is a onetime appropriation that is available until June 30, 2021. The commissioner shall award half of all grant funds to eligible applicants in the metropolitan area and half of all grant funds to eligible applicants outside the metropolitan area. An applicant may apply for and the commissioner may award grants for two-year periods.

Subd. 3. **Allocation of grants.** (a) An application must be on a form and contain information as specified by the commissioner but at a minimum must contain:

(1) a description of the purpose or project for which grant funds will be used;

(2) a description of the specific problem the grant funds will address;

(3) a letter of support from the local mental health authority;

(4) a description of achievable objectives, a work plan, and a timeline for implementation and completion of processes or projects enabled by the grant; and

(5) a process for documenting and evaluating results of the grant.

(b) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications according to paragraph (c), the commissioner shall establish criteria including, but not limited to: the eligibility of the project; the applicant's thoroughness and clarity in describing the problem grant funds are intended to address; a description of the applicant's proposed project; a description of the population demographics and service area of the proposed project; the manner in which the applicant will demonstrate the effectiveness of any projects undertaken; the proposed project's longevity and demonstrated financial sustainability after the initial grant period; and evidence of efficiencies and effectiveness gained through collaborative efforts. The commissioner may also consider other relevant factors. In evaluating applications, the commissioner may request additional information regarding a proposed project, including information on project cost. An applicant's failure to provide the information requested disqualifies an applicant. The commissioner shall determine the number of grants awarded.

(c) Eligible applicants may receive grants under this section for purposes including, but not limited to, the following:

(1) intensive residential treatment services providing time-limited mental health services in a residential setting;

(2) the creation of stand-alone urgent care centers for mental health and psychiatric consultation services, crisis residential services, or collaboration between crisis teams and critical access hospitals;

(3) establishing new community mental health services or expanding the capacity of existing services, including supportive housing; and

(4) other innovative projects that improve options for mental health services in community settings and reduce the number of clients who remain in regional treatment centers and community behavioral health hospitals beyond when discharge is determined to be clinically appropriate.

Subd. 4. **Report to legislature.** By December 1, 2019, the commissioner of human services shall deliver a report to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health issues on the outcomes of the projects funded under this section. The report shall, at a minimum, include the amount of funding awarded for each project, a description of the programs and services funded, plans for the long-term sustainability of the projects, and data on outcomes for the programs and services funded. Grantees must provide information and data requested by the commissioner to support the development of this report.

Sec. 19. **RESIDENTIAL TREATMENT AND PAYMENT RATE REFORM.**

The commissioner shall contract with an outside expert to identify recommendations for the development of a substance use disorder residential treatment program model and payment structure that is not subject to the federal institutions for mental diseases exclusion and that is financially sustainable for providers, while incentivizing best practices and improved treatment outcomes. The analysis must include recommendations and a timeline for supporting providers to transition to the new models of care delivery. No later than December 15, 2018, the commissioner shall deliver a report with recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

Sec. 20. **COMMISSIONER'S DUTY TO SEEK FEDERAL APPROVAL.**

The commissioner of human services shall seek federal approval that is necessary to implement Minnesota Statutes, sections 256B.0621, subdivision 10; and 256B.0625, subdivision 20, for interactive video contact.

Sec. 21. **REPEALER.**

Minnesota Statutes 2016, section 256B.7631, is repealed.

ARTICLE 7

OPIATE ABUSE PREVENTION

Section 1. Minnesota Statutes 2016, section 152.11, is amended by adding a subdivision to read:

Subd. 4. **Limit on quantity of opiates prescribed for acute dental and ophthalmic pain.** (a) When used for the treatment of acute dental pain or acute pain associated with refractive surgery, prescriptions for opiate or narcotic pain relievers listed in Schedules II through IV of section 152.02 shall not exceed a four-day supply. The quantity prescribed shall be consistent with the dosage listed in the professional labeling for the drug that has been approved by the United States Food and Drug Administration.

(b) For the purposes of this subdivision, "acute pain" means pain resulting from disease, accidental or intentional trauma, surgery, or another cause, that the practitioner reasonably expects to last only a short period of time. Acute pain does not include chronic pain or pain being treated as part of cancer care, palliative care, or hospice or other end-of-life care.

(c) Notwithstanding paragraph (a), if in the professional clinical judgment of a practitioner more than a four-day supply of a prescription listed in Schedules II through IV of section 152.02 is required to treat a patient's acute pain, the practitioner may issue a prescription for the quantity needed to treat such acute pain.

Sec. 2. **[152.121] REQUIRED DISCLOSURES FOR PRESCRIPTION OPIOIDS.**

Subdivision 1. **Required information.** (a) When dispensing prescription opioids, a dispenser must provide to a patient, the patient's agent, or the patient's caregiver, clear and conspicuous written information, in plain language, about:

(1) the addictive nature of opioids and the risks of opioid abuse; and

(2) safe disposal of unused prescription opioids. This information must be consistent with the requirements of section 152.105.

(b) For purposes of this section, "dispenser" has the meaning provided in section 152.126, subdivision 1.

Subd. 2. **Board of Pharmacy development of materials.** The Board of Pharmacy shall develop concise written text in plain language that a dispenser may use to comply with the

requirements of subdivision 1. The board shall make this text available to dispensers in the state by posting it on the board's Web site in a format that allows dispensers to download and print it for distribution.

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

Sec. 3. Minnesota Statutes 2016, section 256B.072, is amended to read:

256B.072 PERFORMANCE REPORTING AND QUALITY IMPROVEMENT SYSTEM.

Subdivision 1. **Performance measures.** (a) The commissioner of human services shall establish a performance reporting system for health care providers who provide health care services to public program recipients covered under chapters 256B, 256D, and 256L, reporting separately for managed care and fee-for-service recipients.

(b) The measures used for the performance reporting system for medical groups shall include measures of care for asthma, diabetes, hypertension, and coronary artery disease and measures of preventive care services. The measures used for the performance reporting system for inpatient hospitals shall include measures of care for acute myocardial infarction, heart failure, and pneumonia, and measures of care and prevention of surgical infections. In the case of a medical group, the measures used shall be consistent with measures published by nonprofit Minnesota or national organizations that produce and disseminate health care quality measures or evidence-based health care guidelines. In the case of inpatient hospital measures, the commissioner shall appoint the Minnesota Hospital Association and Stratis Health to advise on the development of the performance measures to be used for hospital reporting. To enable a consistent measurement process across the community, the commissioner may use measures of care provided for patients in addition to those identified in paragraph (a). The commissioner shall ensure collaboration with other health care reporting organizations so that the measures described in this section are consistent with those reported by those organizations and used by other purchasers in Minnesota.

(c) The commissioner may require providers to submit information in a required format to a health care reporting organization or to cooperate with the information collection procedures of that organization. The commissioner may collaborate with a reporting organization to collect information reported and to prevent duplication of reporting.

(d) By October 1, 2007, and annually thereafter, the commissioner shall report through a public Web site the results by medical groups and hospitals, where possible, of the measures under this section, and shall compare the results by medical groups and hospitals for patients

enrolled in public programs to patients enrolled in private health plans. To achieve this reporting, the commissioner may collaborate with a health care reporting organization that operates a Web site suitable for this purpose.

(e) Performance measures must be stratified as provided under section 62U.02, subdivision 1, paragraph (b), and risk-adjusted as specified in section 62U.02, subdivision 3, paragraph (b).

(f) Assessment of patient satisfaction with pain management for the purpose of determining compensation or quality incentive payments is prohibited. The commissioner shall require managed care plans, county-based purchasing plans, and integrated health partnerships to comply with this requirement as a condition of contract. This prohibition does not apply to:

(1) assessing patient satisfaction with pain management for the purpose of quality improvement; and

(2) pain management as a part of a palliative care treatment plan to treat patients with cancer or patients receiving hospice care.

Subd. 2. **Adjustment of quality metrics for special populations.** Notwithstanding subdivision 1, paragraph (b), by January 1, 2019, the commissioner shall consider and appropriately adjust quality metrics and benchmarks for providers who primarily serve socio-economically complex patient populations and request to be scored on additional measures in this subdivision. This requirement applies to all medical assistance and MinnesotaCare programs and enrollees, including persons enrolled in managed care and county-based purchasing plans or other managed care organizations, persons receiving care under fee-for-service, and persons receiving care under value-based purchasing arrangements, including but not limited to initiatives operating under sections 256B.0751, 256B.0753, 256B.0755, 256B.0756, and 256B.0757.

Sec. 4. **OPIOID ABUSE PREVENTION.**

(a) The commissioner of health shall establish opioid abuse prevention pilot projects in geographic areas throughout the state, to reduce opioid abuse through the use of controlled substance care teams and community-wide coordination of abuse-prevention initiatives. The commissioner shall award grants to health care providers, health plan companies, local units of government, or other entities to establish pilot projects.

(b) Each pilot project must:

(1) be designed to reduce emergency room and other health care provider visits resulting from opioid use or abuse, and reduce rates of opioid addiction in the community;

(2) establish multidisciplinary controlled substance care teams, that may consist of physicians, pharmacists, social workers, nurse care coordinators, and mental health professionals;

(3) deliver health care services and care coordination, through controlled substance care teams, to reduce the inappropriate use of opioids by patients and rates of opioid addiction;

(4) address any unmet social service needs that create barriers to managing pain effectively and obtaining optimal health outcomes;

(5) provide prescriber and dispenser education and assistance to reduce the inappropriate prescribing and dispensing of opioids;

(6) promote the adoption of best practices related to opioid disposal and reducing opportunities for illegal access to opioids; and

(7) engage partners outside of the health care system, including schools, law enforcement, and social services, to address root causes of opioid abuse and addiction at the community level.

(c) The commissioner shall contract with an accountable community for health that operates an opioid abuse prevention project, and can document success in reducing opioid use through the use of controlled substance care teams, to assist the commissioner in administering this section, and to provide technical assistance to the commissioner and to entities selected to operate a pilot project.

(d) The contract under paragraph (c) shall require the accountable community for health to evaluate the extent to which the pilot projects were successful in reducing the inappropriate use of opioids. The evaluation must analyze changes in the number of opioid prescriptions, the number of emergency room visits related to opioid use, and other relevant measures. The accountable community for health shall report evaluation results to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance and public safety by December 15, 2019.

Sec. 5. **REPORT ON OPIOID CRISIS GRANT; USE OF GRANT FUNDS.**

(a) The commissioner of human services, by October 1, 2017, shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on:

(1) funds received under the 21st Century Cures Act, Public Law 114-255, section 1003, Substance Abuse and Mental Health Services Administration (SAMHSA) State Targeted Response to the Opioid Crisis Grants; and

(2) uses of the funds received, including a listing of grants provided and the amount expended on personnel and administrative costs, travel, and public service announcements.

(b) The commissioner shall use remaining Opioid Crisis Grant funds, and any additional funds received from other sources, to provide grants to counties for opioid abuse prevention initiatives, increase public awareness of opioid abuse, and prevent opioid abuse through the use of data analytics.

Sec. 6. **CHRONIC PAIN REHABILITATION THERAPY DEMONSTRATION PROJECT.**

Subdivision 1. **Establishment.** The commissioner of human services shall develop and authorize a two-year demonstration project with a rehabilitation institute located in Minneapolis operated by a nonprofit foundation, for a bundled payment arrangement for chronic pain rehabilitation therapy for adults who are eligible for fee-for-service medical assistance under Minnesota Statutes, section 256B.055, subdivision 7, 15, 16, or 17. The chronic pain rehabilitation therapy demonstration project must include: nonnarcotic medication management, including opioid tapering; interdisciplinary care coordination; and group and individual therapy in cognitive behavioral therapy and physical therapy. The project may include self-management education in nutrition, stress, mental health, substance use, or other modalities, if clinically appropriate.

Subd. 2. **Performance and cost savings indicators.** In developing the demonstration project, the commissioner shall identify cost savings indicators in addition to performance indicators including:

(1) reduction in medications, including opioids, taken for pain;

(2) reduction in emergency department and outpatient clinic utilization related to pain;

(3) improved ability to return to work, job search, or school;

(4) patient satisfaction; and

(5) rate of program completion.

Subd. 3. **Eligibility.** To be eligible to participate in the demonstration project, an individual must:

(1) be 18 years of age or older;

(2) be eligible for fee-for-service medical assistance under Minnesota Statutes, section 256B.055, subdivision 7, 15, 16, or 17;

(3) have moderate to severe pain lasting longer than four months;

(4) have an impairment in daily functioning, including work or activities of daily living;

(5) have a referral from a physician or other qualified medical professional indicating that all reasonable medical and surgical options have been exhausted; and

(6) be willing to engage in chronic pain rehabilitation therapies, including opioid tapering.

Subd. 4. **Integrated health partnerships.** The chronic pain rehabilitation therapy demonstration project and participating individuals may be incorporated into the demonstration site's health care delivery systems demonstration under Minnesota Statutes, section 256B.0755, subdivision 1.

Subd. 5. **Report.** The rehabilitation institute, for the duration of the demonstration project, must annually report on cost savings and performance indicators described in subdivision 2 to the commissioner of human services. Three months after the completion of the demonstration project, the commissioner of human services shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care. The report must include successes and limitations of the chronic pain rehabilitation therapy demonstration project and recommendations to increase an individual's access to chronic pain rehabilitation therapy through Minnesota health care programs.

Sec. 7. **SUBSTANCE USE DISORDER PROVIDER CAPACITY GRANT PROGRAM.**

The commissioner of human services shall design and implement a grant program to assist providers to purchase the first dose of a nonnarcotic injectable or implantable medication to treat substance use disorder for medical assistance enrollees. Grants shall be distributed between July 1, 2017, and June 30, 2019. The commissioner shall conduct outreach to providers regarding the availability of this grant and ensure a simplified grant application process. The commissioner shall provide technical assistance to assist providers in building operational capacity to treat substance use disorders with nonnarcotic injectable or implantable medications. The commissioner, in collaboration with stakeholders, shall analyze the impact of the grant program under this section and the actual or perceived barriers for providers to access and be reimbursed for nonnarcotic injectable or implantable substance use disorder medications and develop recommendations for addressing identified barriers. The commissioner shall provide a report to the chairs and ranking minority members

of the legislative committees with jurisdiction over health and human services policy and finance by September 1, 2019.

ARTICLE 8

MISCELLANEOUS

Section 1. Minnesota Statutes 2016, section 62A.671, subdivision 6, is amended to read:

Subd. 6. **Licensed health care provider.** "Licensed health care provider" means a health care provider who is:

(1) licensed under chapter 147, 147A, 148, 148B, 148E, 148F, 150A, or 153; a mental health professional as defined under section 245.462, subdivision 18, or 245.4871, subdivision 27; a mental health practitioner as defined under section 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general supervision of a mental health professional; or a vendor of medical care defined in section 256B.02, subdivision 7; and

(2) authorized within their respective scope of practice to provide the particular service with no supervision or under general supervision.

EFFECTIVE DATE. This section is effective January 1, 2018, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2016, section 151.01, subdivision 5, is amended to read:

Subd. 5. **Drug.** "Drug" means all medicinal substances and preparations recognized by the United States Pharmacopoeia and National Formulary, or any revision thereof~~, vaccines and biologicals, and~~; biological products, other than blood or blood components; all substances and preparations intended for external and internal use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans or other animals~~,~~; and all substances and preparations, other than food, intended to affect the structure or any function of the bodies of humans or other animals. The term drug shall also mean any compound, substance, or derivative that is not approved for human consumption by the United States Food and Drug Administration or specifically permitted for human consumption under Minnesota law, and, when introduced into the body, induces an effect similar to that of a Schedule I or Schedule II controlled substance listed in section 152.02, subdivisions 2 and 3, or Minnesota Rules, parts 6800.4210 and 6800.4220, regardless of whether the substance is marketed for the purpose of human consumption.

Sec. 3. Minnesota Statutes 2016, section 151.01, is amended by adding a subdivision to read:

Subd. 40. **Biological product.** "Biological product" has the meaning given in United States Code, title 42, section 262.

Sec. 4. Minnesota Statutes 2016, section 151.01, is amended by adding a subdivision to read:

Subd. 41. **Interchangeable biological product.** "Interchangeable biological product" means a biological product that the United States Food and Drug Administration has:

(1) licensed, and determined to meet the standards for interchangeability under United States Code, title 42, section 262(k)(4); or

(2) determined to be therapeutically equivalent, as set forth in the most recent edition or supplement of the United States Food and Drug Administration publication titled "Approved Drug Products with Therapeutic Equivalence Evaluations."

Sec. 5. Minnesota Statutes 2016, section 151.21, is amended to read:

151.21 SUBSTITUTION.

Subdivision 1. **Generally.** Except as provided in this section, it shall be unlawful for any pharmacist or pharmacist intern who dispenses prescriptions, drugs, and medicines to substitute an article different from the one ordered, or deviate in any manner from the requirements of ~~an order or~~ a prescription drug order without the approval of the prescriber.

Subd. 2. ~~**Brand name specified**~~ **Dispense as written prescription drug orders.** When a pharmacist receives a paper or hard copy prescription drug order on which the prescriber has personally written in handwriting "dispense as written" or "D.A.W.," a prescription sent by electronic transmission on which the prescriber has expressly indicated in a manner consistent with the standards for electronic prescribing under Code of Federal Regulations, title 42, section 423, that the prescription is to be dispensed as transmitted and which bears the prescriber's electronic signature, or an oral prescription ~~in~~ for which the prescriber has expressly indicated that the prescription is to be dispensed as communicated, the pharmacist shall dispense the ~~brand name legend~~ drug as prescribed.

Subd. 3. ~~**Brand name not specified**~~ **Other prescription drug orders.** When a pharmacist receives a paper or hard copy prescription on which the prescriber has not personally written in handwriting "dispense as written" or "D.A.W.," a prescription sent by electronic transmission on which the prescriber has not expressly indicated in a manner consistent

with the standards for electronic prescribing under Code of Federal Regulations, title 42, section 423, that the prescription is to be dispensed as transmitted and which bears the prescriber's electronic signature, or an oral prescription in which the prescriber has not expressly indicated that the prescription is to be dispensed as communicated, and there is available in the pharmacist's stock a less expensive generically equivalent drug ~~that, in the pharmacist's professional judgment, is safely interchangeable with the prescribed drug~~ or, if a biological product is prescribed, a less expensive interchangeable biological product, then the pharmacist shall, after disclosing the substitution to the purchaser, dispense the ~~generic~~ generically equivalent drug or the interchangeable biological product, unless the purchaser objects. A pharmacist may also substitute pursuant to the oral instructions of the prescriber. A pharmacist may not substitute a generically equivalent drug ~~product~~ unless, in the pharmacist's professional judgment, the substituted drug is therapeutically equivalent and interchangeable to the prescribed drug. A pharmacist may not substitute a biological product unless the United States Food and Drug Administration has determined the substituted biological product to be interchangeable with the prescribed biological product. A pharmacist shall notify the purchaser if the pharmacist is dispensing a drug or biological product other than the ~~brand name~~ specific drug or biological product prescribed.

Subd. 3a. **Prescriptions by electronic transmission.** Nothing in this section permits a prescriber to maintain "dispense as written" or "D.A.W." as a default on all prescriptions. Prescribers must add the "dispense as written" or "D.A.W." designation to electronic prescriptions individually, as appropriate.

Subd. 4. **Pricing.** A pharmacist dispensing a drug under the provisions of subdivision 3 shall not dispense a drug of a higher retail price than that of the ~~brand name~~ drug prescribed. If more than one safely interchangeable ~~generic~~ drug is available in a pharmacist's stock, then the pharmacist shall dispense the least expensive alternative. ~~Any difference between acquisition cost to the pharmacist of the drug dispensed and the brand name drug prescribed shall be passed on to the purchaser.~~

Subd. 4a. **Sign.** A pharmacy must post a sign in a conspicuous location and in a typeface easily seen at the counter where prescriptions are dispensed stating: "In order to save you money, this pharmacy will substitute whenever possible an FDA-approved, less expensive, generic drug product, which is therapeutically equivalent to and safely interchangeable with the one prescribed by your doctor, unless you object to this substitution."

Subd. 5. **Reimbursement.** Nothing in this section requires a pharmacist to substitute a ~~generic~~ drug if the substitution will make the transaction ineligible for third-party reimbursement.

Subd. 6. **Disclosure.** When a pharmacist dispenses a brand name legend drug and, at that time, a less expensive generically equivalent drug or interchangeable biological product is also available in the pharmacist's stock, the pharmacist shall disclose to the purchaser that a ~~generic~~ generically equivalent drug or interchangeable biological product is available.

Subd. 7. **Drug formulary.** This section does not apply when a pharmacist is dispensing a prescribed drug to persons covered under a managed health care plan that maintains a mandatory or closed drug formulary.

Subd. 8. **List of excluded products.** The Drug Formulary Committee established under section 256B.0625, subdivision 13, shall establish a list of drug products that are to be excluded from this section. This list shall be updated on an annual basis and shall be provided to the board for dissemination to pharmacists licensed in the state.

Subd. 9. **Extended supply.** (a) After a patient has obtained an initial 30-day supply of a prescription drug, and the patient returns to the pharmacy to obtain a refill, a pharmacist may dispense up to a 90-day supply of that prescription drug to the patient when the following requirements are met:

(1) the total quantity of dosage units dispensed by the pharmacist does not exceed the total quantity of dosage units of the remaining refills authorized by the prescriber; and

(2) the pharmacist is exercising the pharmacist's professional judgment.

(b) The initial 30-day supply requirement in paragraph (a) is not required if the prescription has previously been filled with a 90-day supply.

(c) Notwithstanding paragraph (a), a pharmacist may not exceed the number of dosage units authorized by a prescriber for an initial prescription or subsequent refills if:

(1) the prescriber has specified on the prescription that, due to medical necessity, the pharmacist may not exceed the number of dosage units identified on the prescription; or

(2) the prescription drug is a controlled substance, as defined in section 152.01, subdivision 4.

Subd. 10. **Electronic entry.** (a) Within five business days following the dispensing of a biological product, the dispensing pharmacist or the pharmacist's designee shall communicate to the prescriber the name and manufacturer of the biological product dispensed.

(b) The communication shall be conveyed by making an entry that is electronically accessible to the prescriber through:

(1) an interoperable electronic medical records system;

(2) an electronic prescribing technology;

(3) a pharmacy benefit management system; or

(4) a pharmacy record.

(c) Entry into an electronic records system as described in paragraph (b) is presumed to provide notice to the prescriber.

(d) When electronic communication as specified in paragraph (b) is not possible, the pharmacist or the pharmacist's designee shall communicate to the prescriber the name and manufacturer of the biological product dispensed by using mail, facsimile, telephone, or other secure means of electronic transmission.

(e) Communication of the name and manufacturer of the biological product dispensed shall not be required if:

(1) there is no United States Food and Drug Administration-approved interchangeable biological product for the product prescribed; or

(2) a prescription is being refilled and the biological product being dispensed is the same product dispensed on the prior filling of the prescription.

Sec. 6. Minnesota Statutes 2016, section 245A.02, subdivision 5a, is amended to read:

Subd. 5a. **Controlling individual.** (a) "Controlling individual" means ~~a public body, governmental agency, business entity, officer, owner, or managerial official whose responsibilities include the direction of the management or policies of a program. For purposes of this subdivision, owner means an individual who has direct or indirect ownership interest in a corporation, partnership, or other business association issued a license under this chapter. For purposes of this subdivision, managerial official means those individuals who have the decision-making authority related to the operation of the program, and the responsibility for the ongoing management of or direction of the policies, services, or employees of the program. A site director who has no ownership interest in the program is not considered to be a managerial official for purposes of this definition. Controlling individual does not include~~ an owner of a program or service provider licensed under this chapter and the following individuals, if applicable:

(1) each officer of the organization, including the chief executive officer and chief financial officer;

(2) the individual designated as the authorized agent under section 245A.04, subdivision 1, paragraph (b);

(3) the individual designated as the compliance officer under section 256B.04, subdivision 21, paragraph (b); and

(4) each managerial official whose responsibilities include the direction of the management or policies of a program.

(b) Controlling individual does not include:

(1) a bank, savings bank, trust company, savings association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity operates a program directly or through a subsidiary;

(2) an individual who is a state or federal official, or state or federal employee, or a member or employee of the governing body of a political subdivision of the state or federal government that operates one or more programs, unless the individual is also an officer, owner, or managerial official of the program, receives remuneration from the program, or owns any of the beneficial interests not excluded in this subdivision;

(3) an individual who owns less than five percent of the outstanding common shares of a corporation:

(i) whose securities are exempt under section 80A.45, clause (6); or

(ii) whose transactions are exempt under section 80A.46, clause (2); ~~or~~

(4) an individual who is a member of an organization exempt from taxation under section 290.05, unless the individual is also an officer, owner, or managerial official of the program or owns any of the beneficial interests not excluded in this subdivision. This clause does not exclude from the definition of controlling individual an organization that is exempt from taxation~~.~~; or

(5) an employee stock ownership plan trust, or a participant or board member of an employee stock ownership plan, unless the participant or board member is a controlling individual according to paragraph (a).

(c) For purposes of this subdivision, "managerial official" means an individual who has the decision-making authority related to the operation of the program, and the responsibility for the ongoing management of or direction of the policies, services, or employees of the program. A site director who has no ownership interest in the program is not considered to be a managerial official for purposes of this definition.

Sec. 7. Minnesota Statutes 2016, section 245A.02, is amended by adding a subdivision to read:

Subd. 10b. **Owner.** "Owner" means an individual or organization that has a direct or indirect ownership interest of five percent or more in a program licensed under this chapter. For purposes of this subdivision, "direct ownership interest" means the possession of equity in capital, stock, or profits of an organization, and "indirect ownership interest" means a direct ownership interest in an entity that has a direct or indirect ownership interest in a licensed program. For purposes of this chapter, "owner of a nonprofit corporation" means the president and treasurer of the board of directors or, for an entity owned by an employee stock ownership plan, means the president and treasurer of the entity. A government entity that is issued a license under this chapter shall be designated the owner.

Sec. 8. **[256.999] LEGISLATIVE NOTICE AND APPROVAL REQUIRED FOR CERTAIN FEDERAL WAIVERS OR APPROVALS.**

(a) Before submitting an application for a federal waiver or approval (1) under section 1332 of the Affordable Care Act or section 1115 of the Social Security Act, or (2) to modify or add a benefit covered by medical assistance or otherwise amend the state's Medicaid plan, the commissioner, governing board, or director of a state agency seeking the federal waiver or approval must provide notice and a copy of the application for the federal waiver or approval to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance and commerce.

(b) If a federal waiver or approval (1) under section 1332 of the Affordable Care Act or section 1115 of the Social Security Act, or (2) to modify or add a benefit covered by medical assistance or otherwise amend the state's Medicaid plan, is received or granted during a legislative session, a commissioner, governing board, or director of a state agency is prohibited from implementing or otherwise acting on the federal waiver or approval received or granted, unless the federal waiver or approval is specifically authorized by law on a date after receipt of the federal waiver or approval.

(c) If a federal waiver or approval (1) under section 1332 of the Affordable Care Act or section 1115 of the Social Security Act, or (2) to modify or add a benefit covered by medical assistance or otherwise amend the state's Medicaid plan, is received or granted while the legislature is not in session, a commissioner, governing board, or director of a state agency is prohibited from implementing or otherwise acting on the federal waiver or approval received or granted, unless the federal waiver or approval is submitted to the Legislative Advisory Commission and the commission makes a positive recommendation. If the

commission makes no recommendation, a negative recommendation, or a recommendation for further review, the commissioner, governing board, or director shall not implement or otherwise act on the federal waiver or approval received or granted.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to initial requests for federal waivers or approvals sought on or after that date.

Sec. 9. **ESTABLISHMENT OF FEDERALLY FACILITATED MARKETPLACE.**

Subdivision 1. **Establishment.** (a) The commissioner of commerce, in cooperation with the secretary of the United States Department of Health and Human Services, shall establish a federally facilitated marketplace for Minnesota for coverage beginning January 1, 2019. The federally facilitated marketplace shall take the place of MNsure, established under Minnesota Statutes, chapter 62V. In working with the secretary of the United States Department of Health and Human Services to implement the federally facilitated marketplace in Minnesota, the commissioner of commerce shall:

(1) seek to incorporate, where appropriate and cost-effective, elements of the Minnesota eligibility system as defined in Minnesota Statutes, section 62V.055, subdivision 1;

(2) regularly consult with stakeholder groups, including but not limited to representatives of state agencies, health care providers, health plan companies, brokers, and consumers; and

(3) seek all available federal grants and funds for state planning and development costs.

(b) All health plans that are offered to Minnesota residents through the federally facilitated marketplace, when implemented, and that are offered by a health carrier that meets the applicability criteria in Minnesota Statutes, section 62K.10, subdivision 1, must satisfy requirements for:

(1) geographic accessibility to providers that at least satisfy the maximum distance or travel times specified in Minnesota Statutes, section 62K.10, subdivisions 2 and 3; and

(2) provider network adequacy that guarantees at least the level of network adequacy required by Minnesota Statutes, section 62K.10, subdivision 4.

For purposes of this paragraph, "health plan" has the meaning given in Minnesota Statutes, section 62A.011, subdivision 3, and "health carrier" has the meaning given in Minnesota Statutes, section 62A.011, subdivision 2.

Subd. 2. **Implementation plan; draft legislation.** The commissioner of commerce, in consultation with the commissioner of human services, the chief information officer of

MN.IT, and the MNsure board, shall develop and present to the 2018 legislature an implementation plan for conversion to a federally facilitated marketplace. The plan must:

(1) address and provide recommendations on the following issues:

(i) the state agency or other entity responsible for state oversight and administration related to the state's use of the federally facilitated marketplace;

(ii) plan management functions, including certification of qualified health plans;

(iii) the operation of navigator and in-person assister programs, and the operation of a call center and Web site; and

(iv) funding for federally facilitated marketplace activities, including a user fee rate that shall not exceed the federal platform user fee rate of two percent of premiums charged for a coverage year; and

(2) include draft legislation for any changes in state law necessary to implement a federally facilitated marketplace, including but not limited to necessary changes to Laws 2013, chapter 84, and technical and conforming changes related to the repeal of Minnesota Statutes, chapter 62V.

Subd. 3. **Vendor contract.** The commissioner of commerce, in consultation with the commissioner of human services, the chief information officer of MN.IT, and the MNsure board, shall contract with a vendor to provide technical assistance in developing and implementing the plan for conversion to a federally facilitated marketplace.

Sec. 10. **REPEALER.**

Minnesota Statutes 2016, sections 62V.01; 62V.02; 62V.03; 62V.04; 62V.05; 62V.051; 62V.055; 62V.06; 62V.07; 62V.08; 62V.09; 62V.10; and 62V.11, are repealed effective January 1, 2019.

ARTICLE 9

NURSING FACILITY TECHNICAL CORRECTIONS

Section 1. Minnesota Statutes 2016, section 144.0722, subdivision 1, is amended to read:

Subdivision 1. **Resident reimbursement classifications.** The commissioner of health shall establish resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under section 144.0721, or under rules established by the commissioner of human services under ~~sections 256B.41 to 256B.48~~

chapter 256R. The reimbursement classifications established by the commissioner must conform to the rules established by the commissioner of human services.

Sec. 2. Minnesota Statutes 2016, section 144.0724, subdivision 1, is amended to read:

Subdivision 1. **Resident reimbursement case mix classifications.** The commissioner of health shall establish resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under this section and according to section ~~256B.438~~ 256R.17.

Sec. 3. Minnesota Statutes 2016, section 144.0724, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given.

(a) "Assessment reference date" or "ARD" means the specific end point for look-back periods in the MDS assessment process. This look-back period is also called the observation or assessment period.

(b) "Case mix index" means the weighting factors assigned to the RUG-IV classifications.

(c) "Index maximization" means classifying a resident who could be assigned to more than one category, to the category with the highest case mix index.

(d) "Minimum data set" or "MDS" means a core set of screening, clinical assessment, and functional status elements, that include common definitions and coding categories specified by the Centers for Medicare and Medicaid Services and designated by the Minnesota Department of Health.

(e) "Representative" means a person who is the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the Office of Ombudsman for Long-Term Care whose assistance has been requested, or any other individual designated by the resident.

(f) "Resource utilization groups" or "RUG" means the system for grouping a nursing facility's residents according to their clinical and functional status identified in data supplied by the facility's minimum data set.

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

(h) "Nursing facility level of care determination" means the assessment process that results in a determination of a resident's or prospective resident's need for nursing facility

level of care as established in subdivision 11 for purposes of medical assistance payment of long-term care services for:

(1) nursing facility services under section 256B.434 or ~~256B.441~~ chapter 256R;

(2) elderly waiver services under section 256B.0915;

(3) CADI and BI waiver services under section 256B.49; and

(4) state payment of alternative care services under section 256B.0913.

Sec. 4. Minnesota Statutes 2016, section 144.0724, subdivision 9, is amended to read:

Subd. 9. **Audit authority.** (a) The commissioner shall audit the accuracy of resident assessments performed under section ~~256B.438~~ 256R.17 through any of the following: desk audits; on-site review of residents and their records; and interviews with staff, residents, or residents' families. The commissioner shall reclassify a resident if the commissioner determines that the resident was incorrectly classified.

(b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

(c) A facility must grant the commissioner access to examine the medical records relating to the resident assessments selected for audit under this subdivision. The commissioner may also observe and speak to facility staff and residents.

(d) The commissioner shall consider documentation under the time frames for coding items on the minimum data set as set out in the Long-Term Care Facility Resident Assessment Instrument User's Manual published by the Centers for Medicare and Medicaid Services.

(e) The commissioner shall develop an audit selection procedure that includes the following factors:

(1) Each facility shall be audited annually. If a facility has two successive audits in which the percentage of change is five percent or less and the facility has not been the subject of a special audit in the past 36 months, the facility may be audited biannually. A stratified sample of 15 percent, with a minimum of ten assessments, of the most current assessments shall be selected for audit. If more than 20 percent of the RUG-IV classifications are changed as a result of the audit, the audit shall be expanded to a second 15 percent sample, with a minimum of ten assessments. If the total change between the first and second samples is 35 percent or greater, the commissioner may expand the audit to all of the remaining assessments.

(2) If a facility qualifies for an expanded audit, the commissioner may audit the facility again within six months. If a facility has two expanded audits within a 24-month period, that facility will be audited at least every six months for the next 18 months.

(3) The commissioner may conduct special audits if the commissioner determines that circumstances exist that could alter or affect the validity of case mix classifications of residents. These circumstances include, but are not limited to, the following:

(i) frequent changes in the administration or management of the facility;

(ii) an unusually high percentage of residents in a specific case mix classification;

(iii) a high frequency in the number of reconsideration requests received from a facility;

(iv) frequent adjustments of case mix classifications as the result of reconsiderations or audits;

(v) a criminal indictment alleging provider fraud;

(vi) other similar factors that relate to a facility's ability to conduct accurate assessments;

(vii) an atypical pattern of scoring minimum data set items;

(viii) nonsubmission of assessments;

(ix) late submission of assessments; or

(x) a previous history of audit changes of 35 percent or greater.

(f) Within 15 working days of completing the audit process, the commissioner shall make available electronically the results of the audit to the facility. If the results of the audit reflect a change in the resident's case mix classification, a case mix classification notice will be made available electronically to the facility, using the procedure in subdivision 7, paragraph (a). The notice must contain the resident's classification and a statement informing the resident, the resident's authorized representative, and the facility of their right to review the commissioner's documents supporting the classification and to request a reconsideration of the classification. This notice must also include the address and telephone number of the Office of Ombudsman for Long-Term Care.

Sec. 5. Minnesota Statutes 2016, section 144A.071, subdivision 3, is amended to read:

Subd. 3. **Exceptions authorizing increase in beds; hardship areas.** (a) The commissioner of health, in coordination with the commissioner of human services, may approve the addition of new licensed and Medicare and Medicaid certified nursing home beds, using the criteria and process set forth in this subdivision.

(b) The commissioner, in cooperation with the commissioner of human services, shall consider the following criteria when determining that an area of the state is a hardship area with regard to access to nursing facility services:

(1) a low number of beds per thousand in a specified area using as a standard the beds per thousand people age 65 and older, in five year age groups, using data from the most recent census and population projections, weighted by each group's most recent nursing home utilization, of the county at the 20th percentile, as determined by the commissioner of human services;

(2) a high level of out-migration for nursing facility services associated with a described area from the county or counties of residence to other Minnesota counties, as determined by the commissioner of human services, using as a standard an amount greater than the out-migration of the county ranked at the 50th percentile;

(3) an adequate level of availability of noninstitutional long-term care services measured as public spending for home and community-based long-term care services per individual age 65 and older, in five year age groups, using data from the most recent census and population projections, weighted by each group's most recent nursing home utilization, as determined by the commissioner of human services using as a standard an amount greater than the 50th percentile of counties;

(4) there must be a declaration of hardship resulting from insufficient access to nursing home beds by local county agencies and area agencies on aging; and

(5) other factors that may demonstrate the need to add new nursing facility beds.

(c) On August 15 of odd-numbered years, the commissioner, in cooperation with the commissioner of human services, may publish in the State Register a request for information in which interested parties, using the data provided under section 144A.351, along with any other relevant data, demonstrate that a specified area is a hardship area with regard to access to nursing facility services. For a response to be considered, the commissioner must receive it by November 15. The commissioner shall make responses to the request for information available to the public and shall allow 30 days for comment. The commissioner shall review responses and comments and determine if any areas of the state are to be declared hardship areas.

(d) For each designated hardship area determined in paragraph (c), the commissioner shall publish a request for proposals in accordance with section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The request for proposals must be published in the State Register by March 15 following receipt of responses to the request for information.

The request for proposals must specify the number of new beds which may be added in the designated hardship area, which must not exceed the number which, if added to the existing number of beds in the area, including beds in layaway status, would have prevented it from being determined to be a hardship area under paragraph (b), clause (1). Beginning July 1, 2011, the number of new beds approved must not exceed 200 beds statewide per biennium. After June 30, 2019, the number of new beds that may be approved in a biennium must not exceed 300 statewide. For a proposal to be considered, the commissioner must receive it within six months of the publication of the request for proposals. The commissioner shall review responses to the request for proposals and shall approve or disapprove each proposal by the following July 15, in accordance with section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The commissioner shall base approvals or disapprovals on a comparison and ranking of proposals using only the criteria in subdivision 4a. Approval of a proposal expires after 18 months unless the facility has added the new beds using existing space, subject to approval by the commissioner, or has commenced construction as defined in section 144A.071, subdivision 1a, paragraph (d). If, after the approved beds have been added, fewer than 50 percent of the beds in a facility are newly licensed, the operating payment rates previously in effect shall remain. If, after the approved beds have been added, 50 percent or more of the beds in a facility are newly licensed, operating payment rates shall be determined according to Minnesota Rules, part 9549.0057, using the limits under ~~section 256B.441~~ sections 256R.23, subdivision 5, and 256R.24, subdivision 3. External fixed costs payment rates must be determined according to section ~~256B.441, subdivision 53~~ 256R.25. Property payment rates for facilities with beds added under this subdivision must be determined in the same manner as rate determinations resulting from projects approved and completed under section 144A.073.

(e) The commissioner may:

(1) certify or license new beds in a new facility that is to be operated by the commissioner of veterans affairs or when the costs of constructing and operating the new beds are to be reimbursed by the commissioner of veterans affairs or the United States Veterans Administration; and

(2) license or certify beds in a facility that has been involuntarily delicensed or decertified for participation in the medical assistance program, provided that an application for relicensure or recertification is submitted to the commissioner by an organization that is not a related organization as defined in section ~~256B.441, subdivision 34~~ 256R.02, subdivision 43, to the prior licensee within 120 days after delicensure or decertification.

Sec. 6. Minnesota Statutes 2016, section 144A.071, subdivision 4a, is amended to read:

Subd. 4a. **Exceptions for replacement beds.** It is in the best interest of the state to ensure that nursing homes and boarding care homes continue to meet the physical plant licensing and certification requirements by permitting certain construction projects. Facilities should be maintained in condition to satisfy the physical and emotional needs of residents while allowing the state to maintain control over nursing home expenditure growth.

The commissioner of health in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(a) to license or certify beds in a new facility constructed to replace a facility or to make repairs in an existing facility that was destroyed or damaged after June 30, 1987, by fire, lightning, or other hazard provided:

(i) destruction was not caused by the intentional act of or at the direction of a controlling person of the facility;

(ii) at the time the facility was destroyed or damaged the controlling persons of the facility maintained insurance coverage for the type of hazard that occurred in an amount that a reasonable person would conclude was adequate;

(iii) the net proceeds from an insurance settlement for the damages caused by the hazard are applied to the cost of the new facility or repairs;

(iv) the number of licensed and certified beds in the new facility does not exceed the number of licensed and certified beds in the destroyed facility; and

(v) the commissioner determines that the replacement beds are needed to prevent an inadequate supply of beds.

Project construction costs incurred for repairs authorized under this clause shall not be considered in the dollar threshold amount defined in subdivision 2;

(b) to license or certify beds that are moved from one location to another within a nursing home facility, provided the total costs of remodeling performed in conjunction with the relocation of beds does not exceed $1,000,000;

(c) to license or certify beds in a project recommended for approval under section 144A.073;

(d) to license or certify beds that are moved from an existing state nursing home to a different state facility, provided there is no net increase in the number of state nursing home beds;

(e) to certify and license as nursing home beds boarding care beds in a certified boarding care facility if the beds meet the standards for nursing home licensure, or in a facility that was granted an exception to the moratorium under section 144A.073, and if the cost of any remodeling of the facility does not exceed $1,000,000. If boarding care beds are licensed as nursing home beds, the number of boarding care beds in the facility must not increase beyond the number remaining at the time of the upgrade in licensure. The provisions contained in section 144A.073 regarding the upgrading of the facilities do not apply to facilities that satisfy these requirements;

(f) to license and certify up to 40 beds transferred from an existing facility owned and operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the same location as the existing facility that will serve persons with Alzheimer's disease and other related disorders. The transfer of beds may occur gradually or in stages, provided the total number of beds transferred does not exceed 40. At the time of licensure and certification of a bed or beds in the new unit, the commissioner of health shall delicense and decertify the same number of beds in the existing facility. As a condition of receiving a license or certification under this clause, the facility must make a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate as a result of the transfers allowed under this paragraph;

(g) to license and certify nursing home beds to replace currently licensed and certified boarding care beds which may be located either in a remodeled or renovated boarding care or nursing home facility or in a remodeled, renovated, newly constructed, or replacement nursing home facility within the identifiable complex of health care facilities in which the currently licensed boarding care beds are presently located, provided that the number of boarding care beds in the facility or complex are decreased by the number to be licensed as nursing home beds and further provided that, if the total costs of new construction, replacement, remodeling, or renovation exceed ten percent of the appraised value of the facility or $200,000, whichever is less, the facility makes a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate by reason of the new construction, replacement, remodeling, or renovation. The provisions contained in section 144A.073 regarding the upgrading of facilities do not apply to facilities that satisfy these requirements;

(h) to license as a nursing home and certify as a nursing facility a facility that is licensed as a boarding care facility but not certified under the medical assistance program, but only if the commissioner of human services certifies to the commissioner of health that licensing the facility as a nursing home and certifying the facility as a nursing facility will result in a net annual savings to the state general fund of $200,000 or more;

(i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home beds in a facility that was licensed and in operation prior to January 1, 1992;

(j) to license and certify new nursing home beds to replace beds in a facility acquired by the Minneapolis Community Development Agency as part of redevelopment activities in a city of the first class, provided the new facility is located within three miles of the site of the old facility. Operating and property costs for the new facility must be determined and allowed under section 256B.431 or 256B.434 or chapter 256R;

(k) to license and certify up to 20 new nursing home beds in a community-operated hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991, that suspended operation of the hospital in April 1986. The commissioner of human services shall provide the facility with the same per diem property-related payment rate for each additional licensed and certified bed as it will receive for its existing 40 beds;

(l) to license or certify beds in renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's remodeling projects do not exceed $1,000,000;

(m) to license and certify beds that are moved from one location to another for the purposes of converting up to five four-bed wards to single or double occupancy rooms in a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity of 115 beds;

(n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing facility located in Minneapolis to layaway all of its licensed and certified nursing home beds. These beds may be relicensed and recertified in a newly constructed teaching nursing home facility affiliated with a teaching hospital upon approval by the legislature. The proposal must be developed in consultation with the interagency committee on long-term care planning. The beds on layaway status shall have the same status as voluntarily delicensed and decertified beds, except that beds on layaway status remain subject to the surcharge in section 256.9657. This layaway provision expires July 1, 1998;

(o) to allow a project which will be completed in conjunction with an approved moratorium exception project for a nursing home in southern Cass County and which is

directly related to that portion of the facility that must be repaired, renovated, or replaced, to correct an emergency plumbing problem for which a state correction order has been issued and which must be corrected by August 31, 1993;

(p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to the commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed wards to single or double occupancy. Beds on layaway status shall have the same status as voluntarily delicensed and decertified beds except that beds on layaway status remain subject to the surcharge in section 256.9657, remain subject to the license application and renewal fees under section 144A.07 and shall be subject to a $100 per bed reactivation fee. In addition, at any time within three years of the effective date of the layaway, the beds on layaway status may be:

(1) relicensed and recertified upon relocation and reactivation of some or all of the beds to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or International Falls; provided that the total project construction costs related to the relocation of beds from layaway status for any facility receiving relocated beds may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073;

(2) relicensed and recertified, upon reactivation of some or all of the beds within the facility which placed the beds in layaway status, if the commissioner has determined a need for the reactivation of the beds on layaway status.

The property-related payment rate of a facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for a facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than three years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(q) to license and certify beds in a renovation and remodeling project to convert 12 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located

in Ramsey County; had a licensed capacity of 154 beds; and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(r) to license and certify up to 117 beds that are relocated from a licensed and certified 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds located in South St. Paul, provided that the nursing facility and hospital are owned by the same or a related organization and that prior to the date the relocation is completed the hospital ceases operation of its inpatient hospital services at that hospital. After relocation, the nursing facility's status shall be the same as it was prior to relocation. The nursing facility's property-related payment rate resulting from the project authorized in this paragraph shall become effective no earlier than April 1, 1996. For purposes of calculating the incremental change in the facility's rental per diem resulting from this project, the allowable appraised value of the nursing facility portion of the existing health care facility physical plant prior to the renovation and relocation may not exceed $2,490,000;

(s) to license and certify two beds in a facility to replace beds that were voluntarily delicensed and decertified on June 28, 1991;

(t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed nursing home and 21-bed boarding care home facility in Minneapolis, notwithstanding the licensure and certification after July 1, 1995, of the Minneapolis facility as a 147-bed nursing home facility after completion of a construction project approved in 1993 under section 144A.073, to be laid away upon 30 days' prior written notice to the commissioner. Beds on layaway status shall have the same status as voluntarily delicensed or decertified beds except that they shall remain subject to the surcharge in section 256.9657. The 16 beds on layaway status may be relicensed as nursing home beds and recertified at any time within five years of the effective date of the layaway upon relocation of some or all of the beds to a licensed and certified facility located in Watertown, provided that the total project construction costs related to the relocation of beds from layaway status for the Watertown facility may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073.

The property-related payment rate of the facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for the facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per

diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than five years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(u) to license and certify beds that are moved within an existing area of a facility or to a newly constructed addition which is built for the purpose of eliminating three- and four-bed rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed capacity of 129 beds;

(v) to relocate 36 beds in Crow Wing County and four beds from Hennepin County to a 160-bed facility in Crow Wing County, provided all the affected beds are under common ownership;

(w) to license and certify a total replacement project of up to 49 beds located in Norman County that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of ~~section 256B.431~~ chapter 256R. Property-related reimbursement rates shall be determined under section ~~256B.431~~ 256R.26, taking into account any federal or state flood-related loans or grants provided to the facility;

(x) to license and certify to the licensee of a nursing home in Polk County that was destroyed by flood in 1997 replacement projects with a total of up to 129 beds, with at least 25 beds to be located in Polk County and up to 104 beds distributed among up to three other counties. These beds may only be distributed to counties with fewer than the median number of age intensity adjusted beds per thousand, as most recently published by the commissioner of human services. If the licensee chooses to distribute beds outside of Polk County under this paragraph, prior to distributing the beds, the commissioner of health must approve the location in which the licensee plans to distribute the beds. The commissioner of health shall consult with the commissioner of human services prior to approving the location of the proposed beds. The licensee may combine these beds with beds relocated from other nursing facilities as provided in section 144A.073, subdivision 3c. The operating payment rates for the new nursing facilities shall be determined based on the interim and settle-up payment provisions of ~~section 256B.431, 256B.434, or 256B.441 or~~ Minnesota Rules, parts 9549.0010 to 9549.0080. Property-related reimbursement rates shall be determined under section

~~256B.431, 256B.434, or 256B.441~~ 256R.26. If the replacement beds permitted under this paragraph are combined with beds from other nursing facilities, the rates shall be calculated as the weighted average of rates determined as provided in this paragraph and section ~~256B.441, subdivision 60~~ 256R.50;

(y) to license and certify beds in a renovation and remodeling project to convert 13 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey County, was not owned by a hospital corporation, had a licensed capacity of 64 beds, and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(z) to license and certify up to 150 nursing home beds to replace an existing 285 bed nursing facility located in St. Paul. The replacement project shall include both the renovation of existing buildings and the construction of new facilities at the existing site. The reduction in the licensed capacity of the existing facility shall occur during the construction project as beds are taken out of service due to the construction process. Prior to the start of the construction process, the facility shall provide written information to the commissioner of health describing the process for bed reduction, plans for the relocation of residents, and the estimated construction schedule. The relocation of residents shall be in accordance with the provisions of law and rule;

(aa) to allow the commissioner of human services to license an additional 36 beds to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that the total number of licensed and certified beds at the facility does not increase;

(bb) to license and certify a new facility in St. Louis County with 44 beds constructed to replace an existing facility in St. Louis County with 31 beds, which has resident rooms on two separate floors and an antiquated elevator that creates safety concerns for residents and prevents nonambulatory residents from residing on the second floor. The project shall include the elimination of three- and four-bed rooms;

(cc) to license and certify four beds in a 16-bed certified boarding care home in Minneapolis to replace beds that were voluntarily delicensed and decertified on or before March 31, 1992. The licensure and certification is conditional upon the facility periodically assessing and adjusting its resident mix and other factors which may contribute to a potential

institution for mental disease declaration. The commissioner of human services shall retain the authority to audit the facility at any time and shall require the facility to comply with any requirements necessary to prevent an institution for mental disease declaration, including delicensure and decertification of beds, if necessary;

(dd) to license and certify 72 beds in an existing facility in Mille Lacs County with 80 beds as part of a renovation project. The renovation must include construction of an addition to accommodate ten residents with beginning and midstage dementia in a self-contained living unit; creation of three resident households where dining, activities, and support spaces are located near resident living quarters; designation of four beds for rehabilitation in a self-contained area; designation of 30 private rooms; and other improvements;

(ee) to license and certify beds in a facility that has undergone replacement or remodeling as part of a planned closure under section ~~256B.437~~ 256R.40;

(ff) to license and certify a total replacement project of up to 124 beds located in Wilkin County that are in need of relocation from a nursing home significantly damaged by flood. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of ~~section 256B.431~~ chapter 256R. Property-related reimbursement rates shall be determined under section ~~256B.431~~ 256R.26, taking into account any federal or state flood-related loans or grants provided to the facility;

(gg) to allow the commissioner of human services to license an additional nine beds to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 240-bed nursing home located in Duluth, provided that the total number of licensed and certified beds at the facility does not increase;

(hh) to license and certify up to 120 new nursing facility beds to replace beds in a facility in Anoka County, which was licensed for 98 beds as of July 1, 2000, provided the new facility is located within four miles of the existing facility and is in Anoka County. Operating and property rates shall be determined and allowed under ~~section 256B.431~~ chapter 256R and Minnesota Rules, parts 9549.0010 to 9549.0080~~, or section 256B.434 or 256B.441~~; or

(ii) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka County that, as of March 25, 2001, is in the active process of closing, to a 122-licensed bed nonprofit nursing facility located in the city of Columbia Heights or its affiliate. The transfer is effective when the receiving facility notifies the commissioner in writing of the number of beds accepted. The commissioner shall place all transferred beds on layaway status held in the name of the receiving facility. The layaway adjustment provisions of section 256B.431,

subdivision 30, do not apply to this layaway. The receiving facility may only remove the beds from layaway for recertification and relicensure at the receiving facility's current site, or at a newly constructed facility located in Anoka County. The receiving facility must receive statutory authorization before removing these beds from layaway status, or may remove these beds from layaway status if removal from layaway status is part of a moratorium exception project approved by the commissioner under section 144A.073.

Sec. 7. Minnesota Statutes 2016, section 144A.071, subdivision 4c, is amended to read:

Subd. 4c. **Exceptions for replacement beds after June 30, 2003.** (a) The commissioner of health, in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(1) to license and certify an 80-bed city-owned facility in Nicollet County to be constructed on the site of a new city-owned hospital to replace an existing 85-bed facility attached to a hospital that is also being replaced. The threshold allowed for this project under section 144A.073 shall be the maximum amount available to pay the additional medical assistance costs of the new facility;

(2) to license and certify 29 beds to be added to an existing 69-bed facility in St. Louis County, provided that the 29 beds must be transferred from active or layaway status at an existing facility in St. Louis County that had 235 beds on April 1, 2003.

The licensed capacity at the 235-bed facility must be reduced to 206 beds, but the payment rate at that facility shall not be adjusted as a result of this transfer. The operating payment rate of the facility adding beds after completion of this project shall be the same as it was on the day prior to the day the beds are licensed and certified. This project shall not proceed unless it is approved and financed under the provisions of section 144A.073;

(3) to license and certify a new 60-bed facility in Austin, provided that: (i) 45 of the new beds are transferred from a 45-bed facility in Austin under common ownership that is closed and 15 of the new beds are transferred from a 182-bed facility in Albert Lea under common ownership; (ii) the commissioner of human services is authorized by the 2004 legislature to negotiate budget-neutral planned nursing facility closures; and (iii) money is available from planned closures of facilities under common ownership to make implementation of this clause budget-neutral to the state. The bed capacity of the Albert Lea facility shall be reduced to 167 beds following the transfer. Of the 60 beds at the new facility, 20 beds shall be used for a special care unit for persons with Alzheimer's disease or related dementias;

(4) to license and certify up to 80 beds transferred from an existing state-owned nursing facility in Cass County to a new facility located on the grounds of the Ah-Gwah-Ching campus. The operating cost payment rates for the new facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of ~~section 256B.431~~ chapter 256R. The property payment rate for the first three years of operation shall be $35 per day. For subsequent years, the property payment rate of $35 per day shall be adjusted for inflation as provided in section 256B.434, subdivision 4, paragraph (c), as long as the facility has a contract under section 256B.434;

(5) to initiate a pilot program to license and certify up to 80 beds transferred from an existing county-owned nursing facility in Steele County relocated to the site of a new acute care facility as part of the county's Communities for a Lifetime comprehensive plan to create innovative responses to the aging of its population. Upon relocation to the new site, the nursing facility shall delicense 28 beds. The payment rate for external fixed costs for the new facility shall be increased by an amount as calculated according to items (i) to (v):

(i) compute the estimated decrease in medical assistance residents served by the nursing facility by multiplying the decrease in licensed beds by the historical percentage of medical assistance resident days;

(ii) compute the annual savings to the medical assistance program from the delicensure of 28 beds by multiplying the anticipated decrease in medical assistance residents, determined in item (i), by the existing facility's weighted average payment rate multiplied by 365;

(iii) compute the anticipated annual costs for community-based services by multiplying the anticipated decrease in medical assistance residents served by the nursing facility, determined in item (i), by the average monthly elderly waiver service costs for individuals in Steele County multiplied by 12;

(iv) subtract the amount in item (iii) from the amount in item (ii);

(v) divide the amount in item (iv) by an amount equal to the relocated nursing facility's occupancy factor under section 256B.431, subdivision 3f, paragraph (c), multiplied by the historical percentage of medical assistance resident days; and

(6) to consolidate and relocate nursing facility beds to a new site in Goodhue County and to integrate these services with other community-based programs and services under a communities for a lifetime pilot program and comprehensive plan to create innovative responses to the aging of its population. Two nursing facilities, one for 84 beds and one for 65 beds, in the city of Red Wing licensed on July 1, 2015, shall be consolidated into a newly

renovated 64-bed nursing facility resulting in the delicensure of 85 beds. Notwithstanding the carryforward of the approval authority in section 144A.073, subdivision 11, the funding approved in April 2009 by the commissioner of health for a project in Goodhue County shall not carry forward. The closure of the 85 beds shall not be eligible for a planned closure rate adjustment under section ~~256B.437~~ 256R.40. The construction project permitted in this clause shall not be eligible for a threshold project rate adjustment under section 256B.434, subdivision 4f. The payment rate for external fixed costs for the new facility shall be increased by an amount as calculated according to items (i) to (vi):

(i) compute the estimated decrease in medical assistance residents served by both nursing facilities by multiplying the difference between the occupied beds of the two nursing facilities for the reporting year ending September 30, 2009, and the projected occupancy of the facility at 95 percent occupancy by the historical percentage of medical assistance resident days;

(ii) compute the annual savings to the medical assistance program from the delicensure by multiplying the anticipated decrease in the medical assistance residents, determined in item (i), by the hospital-owned nursing facility weighted average payment rate multiplied by 365;

(iii) compute the anticipated annual costs for community-based services by multiplying the anticipated decrease in medical assistance residents served by the facilities, determined in item (i), by the average monthly elderly waiver service costs for individuals in Goodhue County multiplied by 12;

(iv) subtract the amount in item (iii) from the amount in item (ii);

(v) multiply the amount in item (iv) by 57.2 percent; and

(vi) divide the difference of the amount in item (iv) and the amount in item (v) by an amount equal to the relocated nursing facility's occupancy factor under section 256B.431, subdivision 3f, paragraph (c), multiplied by the historical percentage of medical assistance resident days.

(b) Projects approved under this subdivision shall be treated in a manner equivalent to projects approved under subdivision 4a.

Sec. 8. Minnesota Statutes 2016, section 144A.071, subdivision 4d, is amended to read:

Subd. 4d. **Consolidation of nursing facilities.** (a) The commissioner of health, in consultation with the commissioner of human services, may approve a request for consolidation of nursing facilities which includes the closure of one or more facilities and the upgrading of the physical plant of the remaining nursing facility or facilities, the costs

of which exceed the threshold project limit under subdivision 2, clause (a). The commissioners shall consider the criteria in this section, section 144A.073, and section ~~256B.437~~ 256R.40, in approving or rejecting a consolidation proposal. In the event the commissioners approve the request, the commissioner of human services shall calculate an external fixed costs rate adjustment according to clauses (1) to (3):

(1) the closure of beds shall not be eligible for a planned closure rate adjustment under section ~~256B.437, subdivision 6~~ 256R.40, subdivision 5;

(2) the construction project permitted in this clause shall not be eligible for a threshold project rate adjustment under section 256B.434, subdivision 4f, or a moratorium exception adjustment under section 144A.073; and

(3) the payment rate for external fixed costs for a remaining facility or facilities shall be increased by an amount equal to 65 percent of the projected net cost savings to the state calculated in paragraph (b), divided by the state's medical assistance percentage of medical assistance dollars, and then divided by estimated medical assistance resident days, as determined in paragraph (c), of the remaining nursing facility or facilities in the request in this paragraph. The rate adjustment is effective on the later of the first day of the month following completion of the construction upgrades in the consolidation plan or the first day of the month following the complete closure of a facility designated for closure in the consolidation plan. If more than one facility is receiving upgrades in the consolidation plan, each facility's date of construction completion must be evaluated separately.

(b) For purposes of calculating the net cost savings to the state, the commissioner shall consider clauses (1) to (7):

(1) the annual savings from estimated medical assistance payments from the net number of beds closed taking into consideration only beds that are in active service on the date of the request and that have been in active service for at least three years;

(2) the estimated annual cost of increased case load of individuals receiving services under the elderly waiver;

(3) the estimated annual cost of elderly waiver recipients receiving support under group residential housing;

(4) the estimated annual cost of increased case load of individuals receiving services under the alternative care program;

(5) the annual loss of license surcharge payments on closed beds;

(6) the savings from not paying planned closure rate adjustments that the facilities would otherwise be eligible for under section ~~256B.437~~ 256R.40; and

(7) the savings from not paying external fixed costs payment rate adjustments from submission of renovation costs that would otherwise be eligible as threshold projects under section 256B.434, subdivision 4f.

(c) For purposes of the calculation in paragraph (a), clause (3), the estimated medical assistance resident days of the remaining facility or facilities shall be computed assuming 95 percent occupancy multiplied by the historical percentage of medical assistance resident days of the remaining facility or facilities, as reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, multiplied by 365.

(d) For purposes of net cost of savings to the state in paragraph (b), the average occupancy percentages will be those reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, and the average payment rates shall be calculated based on the approved payment rates in effect at the time the consolidation request is submitted.

(e) To qualify for the external fixed costs payment rate adjustment under this subdivision, the closing facilities shall:

(1) submit an application for closure according to section ~~256B.437, subdivision 3~~ 256R.40, subdivision 2; and

(2) follow the resident relocation provisions of section 144A.161.

(f) The county or counties in which a facility or facilities are closed under this subdivision shall not be eligible for designation as a hardship area under subdivision 3 for five years from the date of the approval of the proposed consolidation. The applicant shall notify the county of this limitation and the county shall acknowledge this in a letter of support.

Sec. 9. Minnesota Statutes 2016, section 144A.073, subdivision 3c, is amended to read:

Subd. 3c. **Cost neutral relocation projects.** (a) Notwithstanding subdivision 3, the commissioner may at any time accept proposals, or amendments to proposals previously approved under this section, for relocations that are cost neutral with respect to state costs as defined in section 144A.071, subdivision 5a. The commissioner, in consultation with the commissioner of human services, shall evaluate proposals according to subdivision 4a, clauses (1), (4), (5), (6), and (8), and other criteria established in rule or law. The commissioner of human services shall determine the allowable payment rates of the facility

receiving the beds in accordance with section ~~256B.441, subdivision 60~~ 256R.50. The commissioner shall approve or disapprove a project within 90 days.

(b) For the purposes of paragraph (a), cost neutrality shall be measured over the first three 12-month periods of operation after completion of the project.

Sec. 10. Minnesota Statutes 2016, section 144A.10, subdivision 4, is amended to read:

Subd. 4. **Correction orders.** Whenever a duly authorized representative of the commissioner of health finds upon inspection of a nursing home, that the facility or a controlling person or an employee of the facility is not in compliance with sections 144.411 to 144.417, 144.651, 144.6503, 144A.01 to 144A.155, or 626.557 or the rules promulgated thereunder, a correction order shall be issued to the facility. The correction order shall state the deficiency, cite the specific rule or statute violated, state the suggested method of correction, and specify the time allowed for correction. If the commissioner finds that the nursing home had uncorrected or repeated violations which create a risk to resident care, safety, or rights, the commissioner shall notify the commissioner of human services ~~who shall require the facility to use any efficiency incentive payments received under section 256B.431, subdivision 2b, paragraph (d), to correct the violations and shall require the facility to forfeit incentive payments for failure to correct the violations as provided in section 256B.431, subdivision 2n. The forfeiture shall not apply to correction orders issued for physical plant deficiencies~~.

Sec. 11. Minnesota Statutes 2016, section 144A.15, subdivision 2, is amended to read:

Subd. 2. **Appointment of receiver, rental.** If, after hearing, the court finds that receivership is necessary as a means of protecting the health, safety, or welfare of a resident of the facility, the court shall appoint the commissioner of health as a receiver to take charge of the facility. The commissioner may enter into an agreement for a managing agent to work on the commissioner's behalf in operating the facility during the receivership. The court shall determine a fair monthly rental for the facility, taking into account all relevant factors including the condition of the facility. This rental fee shall be paid by the receiver to the appropriate controlling person for each month that the receivership remains in effect but shall be reduced by the amount that the costs of the receivership provided under section ~~256B.495~~ 256R.52 are in excess of the facility rate. The controlling person may agree to waive the fair monthly rent by affidavit to the court. Notwithstanding any other law to the contrary, no payment made to a controlling person by any state agency during a period of

receivership shall include any allowance for profit or be based on any formula which includes an allowance for profit.

Notwithstanding state contracting requirements in chapter 16C, the commissioner shall establish and maintain a list of qualified licensed nursing home administrators, or other qualified persons or organizations with experience in delivering skilled health care services and the operation of long-term care facilities for those interested in being a managing agent on the commissioner's behalf during a state receivership of a facility. This list will be a resource for choosing a managing agent and the commissioner may update the list at any time. A managing agent cannot be someone who: (1) is the owner, licensee, or administrator of the facility; (2) has a financial interest in the facility at the time of the receivership or is a related party to the owner, licensee, or administrator; or (3) has owned or operated any nursing facility or boarding care home that has been ordered into receivership.

Sec. 12. Minnesota Statutes 2016, section 144A.154, is amended to read:

144A.154 RATE RECOMMENDATION.

The commissioner may recommend to the commissioner of human services a review of the rates for a nursing home or boarding care home that participates in the medical assistance program that is in voluntary or involuntary receivership, and that has needs or deficiencies documented by the Department of Health. If the commissioner of health determines that a review of the rate under section ~~256B.495~~ 256R.52 is needed, the commissioner shall provide the commissioner of human services with:

(1) a copy of the order or determination that cites the deficiency or need; and

(2) the commissioner's recommendation for additional staff and additional annual hours by type of employee and additional consultants, services, supplies, equipment, or repairs necessary to satisfy the need or deficiency.

Sec. 13. Minnesota Statutes 2016, section 144A.161, subdivision 10, is amended to read:

Subd. 10. **Facility closure rate adjustment.** Upon the request of a closing facility, the commissioner of human services must allow the facility a closure rate adjustment equal to a 50 percent payment rate increase to reimburse relocation costs or other costs related to facility closure. This rate increase is effective on the date the facility's occupancy decreases to 90 percent of capacity days after the written notice of closure is distributed under subdivision 5 and shall remain in effect for a period of up to 60 days. The commissioner shall delay the implementation of rate adjustments under section ~~256B.437, subdivisions~~

~~3, paragraph (b), and 6, paragraph (a)~~ 256R.40, subdivisions 5 and 6, to offset the cost of this rate adjustment.

Sec. 14. Minnesota Statutes 2016, section 144A.1888, is amended to read:

144A.1888 REUSE OF FACILITIES.

Notwithstanding any local ordinance related to development, planning, or zoning to the contrary, the conversion or reuse of a nursing home that closes or that curtails, reduces, or changes operations shall be considered a conforming use permitted under local law, provided that the facility is converted to another long-term care service approved by a regional planning group under section ~~256B.437~~ 256R.40 that serves a smaller number of persons than the number of persons served before the closure or curtailment, reduction, or change in operations.

Sec. 15. Minnesota Statutes 2016, section 144A.611, subdivision 1, is amended to read:

Subdivision 1. **Nursing homes and certified boarding care homes.** The actual costs of tuition and textbooks and reasonable expenses for the competency evaluation or the nursing assistant training program and competency evaluation approved under section 144A.61, which are paid to nursing assistants or adult training programs pursuant to subdivisions 2 and 4, are a reimbursable expense for nursing homes and certified boarding care homes under section ~~256B.431, subdivision 36~~ 256R.37.

Sec. 16. Minnesota Statutes 2016, section 144A.74, is amended to read:

144A.74 MAXIMUM CHARGES.

A supplemental nursing services agency must not bill or receive payments from a nursing home licensed under this chapter at a rate higher than 150 percent of the sum of the weighted average wage rate, plus a factor determined by the commissioner to incorporate payroll taxes as defined in ~~Minnesota Rules, part 9549.0020, subpart 33~~ section 256R.02, subdivision 37, for the applicable employee classification for the geographic group to which the nursing home is assigned under Minnesota Rules, part 9549.0052. The weighted average wage rates must be determined by the commissioner of human services and reported to the commissioner of health on an annual basis. Wages are defined as hourly rate of pay and shift differential, including weekend shift differential and overtime. Facilities shall provide information necessary to determine weighted average wage rates to the commissioner of human services in a format requested by the commissioner. The maximum rate must include all charges for

administrative fees, contract fees, or other special charges in addition to the hourly rates for the temporary nursing pool personnel supplied to a nursing home.

Sec. 17. Minnesota Statutes 2016, section 256.9657, subdivision 1, is amended to read:

Subdivision 1. **Nursing home license surcharge.** (a) Effective July 1, 1993, each non-state-operated nursing home licensed under chapter 144A shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4. The surcharge shall be calculated as $620 per licensed bed. If the number of licensed beds is reduced, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human services that beds have been delicensed. The nursing home must notify the commissioner of health in writing when beds are delicensed. The commissioner of health must notify the commissioner of human services within ten working days after receiving written notification. If the notification is received by the commissioner of human services by the 15th of the month, the invoice for the second following month must be reduced to recognize the delicensing of beds. Beds on layaway status continue to be subject to the surcharge. The commissioner of human services must acknowledge a medical care surcharge appeal within 30 days of receipt of the written appeal from the provider.

(b) Effective July 1, 1994, the surcharge in paragraph (a) shall be increased to $625.

(c) Effective August 15, 2002, the surcharge under paragraph (b) shall be increased to $990.

(d) Effective July 15, 2003, the surcharge under paragraph (c) shall be increased to $2,815.

(e) The commissioner may reduce, and may subsequently restore, the surcharge under paragraph (d) based on the commissioner's determination of a permissible surcharge.

~~(f) Between April 1, 2002, and August 15, 2004, a facility governed by this subdivision may elect to assume full participation in the medical assistance program by agreeing to comply with all of the requirements of the medical assistance program, including the rate equalization law in section 256B.48, subdivision 1, paragraph (a), and all other requirements established in law or rule, and to begin intake of new medical assistance recipients. Rates will be determined under Minnesota Rules, parts 9549.0010 to 9549.0080. Rate calculations will be subject to limits as prescribed in rule and law. Other than the adjustments in sections 256B.431, subdivisions 30 and 32; 256B.437, subdivision 3, paragraph (b), Minnesota Rules, part 9549.0057, and any other applicable legislation enacted prior to the finalization~~

~~of rates, facilities assuming full participation in medical assistance under this paragraph are not eligible for any rate adjustments until the July 1 following their settle-up period.~~

Sec. 18. Minnesota Statutes 2016, section 256B.0915, subdivision 3e, is amended to read:

Subd. 3e. **Customized living service rate.** (a) Payment for customized living services shall be a monthly rate authorized by the lead agency within the parameters established by the commissioner. The payment agreement must delineate the amount of each component service included in the recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized.

(b) The payment rate must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes shall use tools issued by the commissioner to develop and document customized living service plans and rates.

(c) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale. Customized living services must not include rent or raw food costs.

(d) With the exception of individuals described in subdivision 3a, paragraph (b), the individualized monthly authorized payment for the customized living service plan shall not exceed 50 percent of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0051 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a). Effective on July 1 of the state fiscal year in which the resident assessment system as described in section ~~256B.438~~ 256R.17 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly authorized payment for the services described in this clause shall not exceed the limit which was in effect on June 30 of the previous state fiscal year updated annually based on legislatively adopted changes to all service rate maximums for home and community-based service providers.

(e) Effective July 1, 2011, the individualized monthly payment for the customized living service plan for individuals described in subdivision 3a, paragraph (b), must be the monthly authorized payment limit for customized living for individuals classified as case mix A, reduced by 25 percent. This rate limit must be applied to all new participants enrolled in

the program on or after July 1, 2011, who meet the criteria described in subdivision 3a, paragraph (b). This monthly limit also applies to all other participants who meet the criteria described in subdivision 3a, paragraph (b), at reassessment.

(f) Customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

(g) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (d), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

(h) Effective July 1, 2016, and each July 1 thereafter, individualized service rate limits for customized living services under this subdivision shall be increased by the difference between any legislatively adopted home and community-based provider rate increases effective on July 1 or since the previous July 1 and the average statewide percentage increase in nursing facility operating payment rates under ~~sections 256B.431, 256B.434, and 256B.441~~ chapter 256R, effective the previous January 1. This paragraph shall only apply if the average statewide percentage increase in nursing facility operating payment rates is greater than any legislatively adopted home and community-based provider rate increases effective on July 1, or occurring since the previous July 1.

Sec. 19. Minnesota Statutes 2016, section 256B.35, subdivision 4, is amended to read:

Subd. 4. **Field audits required.** The commissioner of human services shall conduct field audits at the same time as cost report audits required under section ~~256B.27, subdivision 2a~~ 256R.13, subdivision 1, and at any other time but at least once every four years, without notice, to determine whether this section was complied with and that the funds provided residents for their personal needs were actually expended for that purpose.

Sec. 20. Minnesota Statutes 2016, section 256B.431, subdivision 30, is amended to read:

Subd. 30. **Bed layaway and delicensure.** (a) For rate years beginning on or after July 1, 2000, a nursing facility reimbursed under this section which has placed beds on layaway shall, for purposes of application of the downsizing incentive in subdivision 3a, paragraph (c), and calculation of the rental per diem, have those beds given the same effect as if the beds had been delicensed so long as the beds remain on layaway. At the time of a layaway, a facility may change its single bed election for use in calculating capacity days under

Minnesota Rules, part 9549.0060, subpart 11. The property payment rate increase shall be effective the first day of the month following the month in which the layaway of the beds becomes effective under section 144A.071, subdivision 4b.

(b) For rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434 or chapter 256R, a nursing facility reimbursed under that section or chapter which has placed beds on layaway shall, for so long as the beds remain on layaway, be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) retain or change the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and

(3) establish capacity days based on the number of beds immediately prior to the layaway and the number of beds after the layaway.

The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the layaway of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 or chapter 256R completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4, paragraph (c). The property payment rate increase shall be effective the first day of the month following the month in which the layaway of the beds becomes effective.

(c) If a nursing facility removes a bed from layaway status in accordance with section 144A.071, subdivision 4b, the commissioner shall establish capacity days based on the number of licensed and certified beds in the facility not on layaway and shall reduce the nursing facility's property payment rate in accordance with paragraph (b).

(d) For the rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434 or chapter 256R, a nursing facility reimbursed under that section or chapter, which has delicensed beds after July 1, 2000, by giving notice of the delicensure to the commissioner of health according to the notice requirements in section 144A.071, subdivision 4b, shall be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) retain or change the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and

(3) establish capacity days based on the number of beds immediately prior to the delicensure and the number of beds after the delicensure.

The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the delicensure of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4, paragraph (c). The property payment rate increase shall be effective the first day of the month following the month in which the delicensure of the beds becomes effective.

(e) For nursing facilities reimbursed under this section ~~or~~, section 256B.434, or chapter 256R, any beds placed on layaway shall not be included in calculating facility occupancy as it pertains to leave days defined in Minnesota Rules, part 9505.0415.

(f) For nursing facilities reimbursed under this section ~~or~~, section 256B.434, or chapter 256R, the rental rate calculated after placing beds on layaway may not be less than the rental rate prior to placing beds on layaway.

(g) A nursing facility receiving a rate adjustment as a result of this section shall comply with section ~~256B.47, subdivision 2~~ 256R.06, subdivision 5.

(h) A facility that does not utilize the space made available as a result of bed layaway or delicensure under this subdivision to reduce the number of beds per room or provide more common space for nursing facility uses or perform other activities related to the operation of the nursing facility shall have its property rate increase calculated under this subdivision reduced by the ratio of the square footage made available that is not used for these purposes to the total square footage made available as a result of bed layaway or delicensure.

Sec. 21. Minnesota Statutes 2016, section 256B.50, subdivision 1, is amended to read:

Subdivision 1. **Scope.** A provider may appeal from a determination of a payment rate established pursuant to this chapter or allowed costs under ~~section 256B.441~~ chapter 256R if the appeal, if successful, would result in a change to the provider's payment rate or to the calculation of maximum charges to therapy vendors as provided by section ~~256B.433, subdivision 3~~ 256R.54. Appeals must be filed in accordance with procedures in this section.

This section does not apply to a request from a resident or long-term care facility for reconsideration of the classification of a resident under section 144.0722.

Sec. 22. **EFFECTIVE DATE.**

Sections 1 to 21 are effective the day following final enactment.

ARTICLE 10

HUMAN SERVICES FORECAST ADJUSTMENTS

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

The dollar amounts shown are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2015, chapter 71, article 14, as amended by Laws 2016, chapter 189, articles 22 and 23, from the general fund, or any other fund named, to the Department of Human Services for the purposes specified in this article, to be available for the fiscal years indicated for each purpose. The figure "2017" used in this article means that the appropriations listed are available for the fiscal year ending June 30, 2017.

	APPROPRIATIONS Available for the Year Ending June 30 2017
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**	
Subdivision 1. **Total Appropriation**	**$ (342,045,000)**
Appropriations by Fund	
2017	
General Fund (198,450,000)	
Health Care Access (146,590,000)	
TANF 2,995,000	
Subd. 2. **Forecasted Programs**	
(a) **MFIP/DWP Grants**	
Appropriations by Fund	
General Fund (2,111,000)	
TANF 2,579,000	
(b) **MFIP Child Care Assistance Grants**	(6,513,000)
(c) **General Assistance Grants**	(4,219,000)

(d) **Minnesota Supplemental Aid Grants** (581,000)

(e) **Group Residential Housing Grants** (533,000)

(f) **Northstar Care for Children** 2,613,000

(g) **MinnesotaCare Grants** (145,883,000)

This appropriation is from the health care access fund.

(h) **Medical Assistance Grants**

	Appropriations by Fund
General Fund	(192,744,000)
Health Care Access	(707,000)

(i) **Alternative Care Grants** -0-

(j) **CD Entitlement Grants** 5,638,000

Subd. 3. **Technical Activities** 416,000

This appropriation is from the TANF fund.

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment.

ARTICLE 11

APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2018" and "2019" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2018, or June 30, 2019, respectively. "The first year" is fiscal year 2018. "The second year" is fiscal year 2019. "The biennium" is fiscal years 2018 and 2019.

APPROPRIATIONS

Available for the Year

Ending June 30

		2018	2019
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**			
Subdivision 1. **Total Appropriation**	$	**7,303,313,000**	$ **7,360,110,000**

Appropriations by Fund

	2018	2019
General	6,755,068,000	6,813,850,000
State Government Special Revenue	4,274,000	4,274,000
Health Care Access	263,748,000	279,216,000
Federal TANF	278,051,000	260,497,000
Lottery Prize	1,896,000	1,896,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **TANF Maintenance of Effort**

(a) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1. In order to meet these basic TANF/MOE requirements, the commissioner may report as TANF/MOE expenditures only nonfederal money expended for allowable activities listed in the following clauses:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative

costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671;

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674; and

(8) qualifying Head Start expenditures under Minnesota Statutes, section 119A.50.

(b) For the activities listed in paragraph (a), clauses (2) to (8), the commissioner may report only expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) The commissioner shall ensure that the MOE used by the commissioner of management and budget for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required

under Code of Federal Regulations, title 45, section 263.1.

(d) The commissioner may not claim an amount of TANF/MOE in excess of the 75 percent standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43 (a)(2).

(e) For the purposes of paragraph (d), the commissioner may supplement the MOE claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision.

(f) The requirement in Minnesota Statutes, section 256.011, subdivision 3, that federal grants or aids secured or obtained under that

subdivision be used to reduce any direct appropriations provided by law, does not apply if the grants or aids are federal TANF funds.

(g) **IT Appropriations Generally.** This appropriation includes funds for information technology projects, services, and support. Notwithstanding Minnesota Statutes, section 16E.0466, funding for information technology project costs shall be incorporated into the service level agreement and paid to the Office of MN.IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(h) **Receipts for Systems Project.** Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, ISDS, METS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the commissioner of the Office of MN.IT Services, funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

Subd. 3. **Central Office; Operations**

	Appropriations by Fund	
General	105,250,000	103,417,000

State Government		
Special Revenue	4,149,000	4,149,000
Health Care Access	20,025,000	20,025,000
Federal TANF	100,000	100,000

(a) **Administrative Recovery; Set-Aside.** The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

(1) Minnesota Statutes, section 125A.744, subdivision 3;

(2) Minnesota Statutes, section 245.495, paragraph (b);

(3) Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

(b) **Base Level Adjustments.** The general fund base is $103,727,000 in fiscal year 2020 and $103,727,000 in fiscal year 2021.

Subd. 4. **Central Office; Children and Families**

	Appropriations by Fund	
General	9,509,000	9,499,000
Federal TANF	2,582,000	2,582,000

(a) **Financial Institution Data Match and Payment of Fees.** The commissioner is authorized to allocate up to $310,000 each year in fiscal year 2018 and fiscal year 2019 from the systems special revenue account to

make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

(b) **Base Level Adjustment.** The general fund base is $9,499,000 in fiscal year 2020 and $9,499,000 in fiscal year 2021.

Subd. 5. **Central Office; Health Care**

	Appropriations by Fund	
General	17,907,000	16,915,000
Health Care Access	19,585,000	19,692,000

(a) **Rates Study.** $227,000 in fiscal year 2018 is from the general fund for the medical assistance payment rate study. This is a onetime appropriation.

(b) **Implementation and Operation of an Electronic Service Delivery Documentation System.** $225,000 in fiscal year 2018 and $183,000 in fiscal year 2019 are from the general fund for the development and implementation of an electronic service delivery documentation system. This is a onetime appropriation.

(c) **Audits.** $153,000 in fiscal year 2018 and $153,000 in fiscal year 2019 are from the general fund for transfer to the Office of the Legislative Auditor for the auditor to establish and maintain a team of auditors with the training and experience necessary to fulfill the requirements in Minnesota Statutes, section 3.972, subdivision 2a.

(d) **Savings from Improved Eligibility Verification.** The commissioner of human services shall implement periodic data matching under Minnesota Statutes, section 256B.0561, the recommendations of the legislative auditor provided under Minnesota Statutes, section 3.972, subdivision 2a, and other eligibility verification initiatives for enrollees or beneficiaries of all health care, income maintenance, and social service programs administered by the commissioner, in a manner sufficient to achieve savings of $80,000,000 in fiscal year 2018 and $90,000,000 in fiscal year 2019.

(e) **Chronic Pain Rehabilitation Therapy Demonstration Project.** $1,000,000 in fiscal year 2018 is from the general fund for a chronic pain rehabilitation therapy demonstration project with a rehabilitation institute. This is a onetime appropriation.

(f) **Base Level Adjustments.** The general fund base is $16,450,000 in fiscal year 2020 and $16,448,000 in fiscal year 2021. The health care access fund base is $19,692,000 in fiscal year 2020 and $19,692,000 in fiscal year 2021.

Subd. 6. **Central Office; Continuing Care for Older Adults**

	Appropriations by Fund	
General	14,386,000	14,357,000
State Government Special Revenue	125,000	125,000

(a) **Alzheimer's Disease Working Group.** $83,000 in fiscal year 2018 and $71,000 in fiscal year 2019 are from the general fund for the Alzheimer's disease working group. This is a onetime appropriation.

(b) **Base Level Adjustment.** The general fund base is $14,297,000 in fiscal year 2020 and $14,297,000 in fiscal year 2021.

Subd. 7. **Central Office; Community Supports**

	Appropriations by Fund	
General	28,103,000	27,011,000
Lottery Prize	163,000	163,000

(a) **Deaf and Hard-of-Hearing Services.** $850,000 in fiscal year 2018 and $700,000 in fiscal year 2019 are from the general fund for the Deaf and Hard-of-Hearing Services Division under Minnesota Statutes, section 256C.233. $150,000 of this appropriation each year must be used for technology improvements, technology support, and training for staff on the use of technology for external-facing services to implement Minnesota Statutes, section 256C.24, subdivision 2, paragraph (a), clause (12).

(b) **Individual Budgeting Model.** $435,000 in fiscal year 2018 and $65,000 in fiscal year 2019 are from the general fund for the commissioner of human services to study and develop an individual budgeting model for disability waiver recipients and those accessing services through consumer-directed community supports. The commissioner shall submit recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over these programs by January 15, 2019. This is a onetime appropriation.

(c) **Home and Community-Based Services Reform Waiver Consolidation.** $72,000 in fiscal year 2018 and $105,000 in fiscal year

2019 are from the general fund for the commissioner to conduct a study on consolidating the four disability home and community-based services waivers into one program. This is a onetime appropriation and the unencumbered balance in the first year does not cancel but is available in the second year. Based on the finding of the consolidation study, the commissioner shall submit recommendations for consolidation of the four home and community-based services waivers into one program to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services by January 15, 2019.

(d) **Base Level Adjustment.** The general fund base is $26,012,000 in fiscal year 2020 and $26,012,000 in fiscal year 2021.

Subd. 8. **Forecasted Programs; MFIP/DWP**

Appropriations by Fund		
General	88,930,000	98,537,000
Federal TANF	92,732,000	75,025,000

Subd. 9. **Forecasted Programs; MFIP Child Care Assistance**	112,178,000	110,791,000
Subd. 10. **Forecasted Programs; General Assistance**	55,536,000	57,221,000

(a) **General Assistance Standard.** The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

(b) **Emergency General Assistance.** The amount appropriated for emergency general assistance is limited to no more than $6,729,812 in fiscal year 2018 and $6,729,812 in fiscal year 2019. Funds to counties shall be allocated by the commissioner using the allocation method under Minnesota Statutes, section 256D.06.

Subd. 11. **Forecasted Programs; Minnesota Supplemental Aid**	40,484,000	41,634,000
Subd. 12. **Forecasted Programs; Group Residential Housing**	170,337,000	180,668,000
Subd. 13. **Forecasted Programs; Northstar Care for Children**	80,542,000	96,433,000
Subd. 14. **Forecasted Programs; MinnesotaCare**	12,172,000	12,763,000

This appropriation is from the health care access fund.

Subd. 15. **Forecasted Programs; Medical Assistance**

Appropriations by Fund		
General	5,146,749,000	5,162,848,000
Health Care Access	210,866,000	225,636,000

(a) **Behavioral Health Services.** $1,000,000 each fiscal year is for behavioral health services provided by hospitals identified under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (a), clause (4). The increase in payments shall be made by increasing the adjustment under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (e), clause (2).

(b) **Integrated Health Partnerships.** $375,000 in fiscal year 2018 and $250,000 in fiscal year 2019 are from the general fund for the commissioner to provide financial assistance to participating providers for costs

required to establish an integrated health partnership, including but not limited to collecting and reporting information on health outcomes, quality of care, and health care costs; training practitioners and staff to use new care models and participate in care coordination; or participating in research and evaluation of the projects. This is a onetime appropriation.

(c) **Vendor contract.** $125,000 in fiscal year 2018 and $250,000 in fiscal year 2019 are from the general fund for the commissioner to contract with state-certified health information exchange (HIE) vendors in order to support providers participating in an integrated health partnership under Minnesota Statutes, section 256B.0755, to connect enrollees with community supports and social services and improve collaboration among participating and authorized providers.

(d) **Contingent Rate Reductions.** If the commissioner determines that competitive bidding reform, health care delivery pilot projects, and hospital and managed care organization outcomes will not achieve a state general fund savings of $204,905,000 for the biennium beginning July 1, 2017, the commissioner shall calculate an estimate of the shortfall in savings and, for fiscal year 2019, shall reduce medical assistance provider payment rates, including but not limited to rates to individual health care providers and provider agencies, hospitals, other residential settings, and capitation rates provided to managed care and county-based purchasing

plans, but excluding nursing facilities, by the amount necessary to recoup the shortfall in savings over that fiscal year.

(e) **Base Level Adjustment.** The health care access fund base for medical assistance is $225,636,000 in fiscal year 2020 and $225,636,000 in fiscal year 2021.

Subd. 16. **Forecasted Programs; Alternative Care** 44,250,000 44,833,000

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

Subd. 17. **Forecasted Programs; Chemical Dependency Treatment Fund** 119,251,000 138,117,000

Subd. 18. **Grant Programs; Support Services Grants**

Appropriations by Fund		
General	8,715,000	8,715,000
Federal TANF	96,311,000	96,311,000

Subd. 19. **Grant Programs; Basic Sliding Fee Child Care Assistance Grants** 51,945,000 48,660,000

Base Level Adjustment. The general fund base is $48,737,000 in fiscal year 2020 and $48,809,000 in fiscal year 2021.

Subd. 20. **Grant Programs; Child Care Development Grants** 1,737,000 1,737,000

Subd. 21. **Grant Programs; Child Support Enforcement Grants** 50,000 50,000

Subd. 22. **Grant Programs; Children's Services Grants**

Appropriations by Fund		
General	40,465,000	40,265,000
Federal TANF	140,000	140,000

(a) **Title IV-E Adoption Assistance.** Additional federal reimbursement to the state as a result of the Fostering Connections to Success and Increasing Adoptions Act's expanded eligibility for title IV-E adoption assistance is appropriated to the commissioner for postadoption, foster care, adoption, and kinship services, including a parent-to-parent support network.

(b) **Adoption Assistance Incentive Grants.** Federal funds available during fiscal years 2018 and 2019 for adoption incentive grants are appropriated to the commissioner for postadoption, foster care, adoption, and kinship services, including a parent-to-parent support network.

(c) **Crisis Nursery Services.** $200,000 in fiscal year 2018 is from the general fund for a grant to an organization in Minneapolis that provides free, voluntary crisis nursery services for families in crisis 24 hours per day, 365 days per year; crisis counseling; overnight residential child care; a 24-hour crisis hotline; and parent education to provide a trauma-informed continuum of care for families living in poverty, to continue efforts to prevent child abuse and neglect, and to develop practices that can be shared with organizations around the state to reduce child abuse and neglect. This is a onetime appropriation.

(d) **White Earth Band of Ojibwe Child Welfare Services.** $1,600,000 in fiscal year 2018 and $1,600,000 in fiscal year 2019 are from the general fund for a grant to the White

Earth Band of Ojibwe for purposes of delivering child welfare services.

Subd. 23. **Grant Programs; Children and Community Service Grants** 58,201,000 58,201,000

Subd. 24. **Grant Programs; Children and Economic Support Grants** 35,760,000 33,000,000

(a) **Minnesota Food Assistance Program.** Unexpended funds for the Minnesota food assistance program for fiscal year 2018 do not cancel but are available for this purpose in fiscal year 2019.

(b) **Long-term Homeless Supportive Services.** $500,000 in fiscal year 2018 and $500,000 in fiscal year 2019 are for the long-term homeless supportive services fund under Minnesota Statutes, section 256K.26. This is a onetime appropriation.

(c) **Housing with Supports.** $750,000 in fiscal year 2018 and $750,000 in fiscal year 2019 are for the housing with supports for adults with serious mental illness grant under Minnesota Statutes, section 245.4661, subdivision 9, paragraph (a), clause (2). This is a onetime appropriation.

(d) **Transitional Housing.** $250,000 in fiscal year 2018 and $250,000 in fiscal year 2019 are for the transitional housing program under Minnesota Statutes, section 256E.33. This is a onetime appropriation.

(e) **Emergency Services Program.** $125,000 in fiscal year 2018 and $125,000 in fiscal year 2019 are for the emergency services program, which provides services and emergency shelter for homeless Minnesotans under Minnesota

Statutes, section 256E.36. This is a onetime appropriation.

(f) **Mobile Food Shelf Grants.** $2,000,000 in fiscal year 2018 is for mobile food shelf grants. Of this amount, $1,000,000 is for sustaining existing mobile programs and $1,000,000 is for creating new mobile programs. The unencumbered balance in the first year does not cancel but is available for the second year. This is a onetime appropriation.

(g) **Food Shelf Programs.** $565,000 in fiscal year 2018 and $565,000 in fiscal year 2019 are for food shelf programs under Minnesota Statutes, section 256E.34. This appropriation may be used to purchase proteins, fruits, vegetables, and diapers.

(h) **Dental Services Grants.** $500,000 in fiscal year 2018 and $500,000 in fiscal year 2019 are for the commissioner to award dental services grants. This is a onetime appropriation. The commissioner may award grants under this section to:

(1) nonprofit community clinics;

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) hospital-based dental clinics owned and operated by a city, county, or former state hospital as defined in Minnesota Statutes, section 62Q.19, subdivision 1, paragraph (a), clause (4); and

(4) a dental clinic owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system.

Grants may be used to fund costs related to maintaining, coordinating, and improving access for medical assistance and MinnesotaCare enrollees to dental care in a region.

The commissioner shall consider the following in awarding the grants: experience in delivering dental services to medical assistance and MinnesotaCare enrollees in urban and rural communities; the potential to successfully maintain or expand access to dental services for medical assistance and MinnesotaCare enrollees; and demonstrated capability to provide access to care for children, adults, and seniors with special needs, individuals with complex medical and dental needs, recent immigrants and non-English speakers, and students attending schools with a high percentage of low-income students.

(i) **Community Action Grants.** $1,000,000 in fiscal year 2018 and $1,000,000 in fiscal year 2019 are for purposes of community action grants under Minnesota Statutes, sections 256E.30 to 256E.32. This is a onetime appropriation.

(j) **Health and Wellness Center.** $200,000 in fiscal year 2018 and $200,000 in fiscal year 2019 are for a grant to a health and wellness center located in North Minneapolis that is a federally qualified health center. This is a onetime appropriation. The center must use the grant money to offer coparent services to unmarried parents. The center must develop a process to inform and educate unmarried

parents about the center's coparent services. The coparent services must include the following:

(1) coparenting workshops for the unmarried parents;

(2) assistance to the unmarried parents in developing a parenting plan that specifies a schedule of the time each parent spends with the child, child support obligations, and a designation of decision-making responsibilities regarding the child's education, medical needs, and religious upbringing;

(3) an assessment of social services needs for each parent; and

(4) additional social services support, including support related to employment, education, and housing.

The parenting plan assistance must include the option of using private mediation.

The coparent workshops must focus at a minimum on (i) the benefits to the child of having both parents involved in a child's life, (ii) promoting both parents' participation in a child's life, (iii) building coparenting and communication skills, (iv) information on establishing paternity, (v) assisting parents in developing a parenting plan, and (vi) educating participants on how to foster a nonresident parent's continued involvement in a child's life.

(k) **Safe Harbor Program.** $300,000 in fiscal year 2018 and $300,000 in fiscal year 2019 are for emergency shelter and transitional and long-term housing beds for sexually exploited

youth and youth at risk of sexual exploitation. Youth 24 years of age or younger are eligible for shelter and housing beds under this paragraph. In funding shelter and housing beds, the commissioner shall emphasize activities that promote capacity-building and development of resources in greater Minnesota. This is a onetime appropriation.

(l) **Family Assets for Independence in Minnesota.** $250,000 in fiscal year 2018 and $250,000 in fiscal year 2019 are for the purposes described in Minnesota Statutes, section 256E.35, family assets for independence in Minnesota.

(m) **Girls' Ranch, Benson.** $970,000 in fiscal year 2018 is for a grant to a girls' ranch in Benson that provides housing, supportive services, educational services, and equine therapy, for purposes of predesigning, designing, constructing, furnishing, and equipping a house with capacity for ten beds, and a second horse riding arena. This is a onetime appropriation.

(n) **Base Level Adjustment.** The general fund base is $29,125,000 in fiscal year 2020 and $29,125,000 in fiscal year 2021.

Subd. 25. **Grant Programs; Health Care Grants**

Appropriations by Fund		
General	5,044,000	4,611,000
Health Care Access	350,000	350,000

Provider Capacity Grants. $425,000 in fiscal year 2018 and $400,000 in fiscal year 2019 are from the general fund for the commissioner to provide substance use disorder provider

capacity grants. Of the appropriation for fiscal year 2018, $25,000 is for administrative costs. This is a onetime appropriation.

Subd. 26. **Grant Programs; Other Long-Term Care Grants** 1,500,000 1,925,000

Subd. 27. **Grant Programs; Aging and Adult Services Grants** 28,837,000 28,362,000

(a) **Caregiver Support Programs.** $200,000 in fiscal year 2018 and $200,000 in fiscal year 2019 are for the purposes of caregiver support programs under Minnesota Statutes, section 256.9755.

(b) **Advanced In-Home Activity-Monitoring Systems.** $40,000 in fiscal year 2018 is for a grant to a local research organization with expertise in identifying current and potential support systems and examining the capacity of those systems to meet the needs of the growing population of elderly persons to conduct a comprehensive assessment of current literature, past research, and an environmental scan of the field related to advanced in-home activity-monitoring systems for elderly persons. The commissioner must report the results of the assessment by January 15, 2018, to the legislative committees and divisions with jurisdiction over health and human services policy and finance. This is a onetime appropriation.

(c) **Base Level Adjustment.** The general fund base is $28,797,000 in fiscal year 2020 and $28,362,000 in fiscal year 2021.

Subd. 28. **Grant Programs; Deaf and Hard-of-Hearing Grants** 2,625,000 2,775,000

Deaf and Hard-of-Hearing Grants. $750,000 in fiscal year 2018 and $900,000 in fiscal year 2019 are for deaf and hard-of-hearing grants. The funds must be used to provide services to Minnesotans who are deafblind under Minnesota Statutes, section 256C.261, to provide culturally affirmative psychiatric services, and to provide linguistically and culturally appropriate mental health services to children who are deaf, children who are deafblind, and children who are hard-of-hearing. Of this appropriation, $103,000 each year is to increase the grant to provide mentors who have hearing loss to parents of infants and children with newly identified hearing loss. Each year the division must provide funds for training in ProTactile American Sign Language or other communication systems used by people who are deafblind. Training shall be provided to persons who are deafblind and to interpreters, support service providers, and intervenors who work with persons who are deafblind.

Subd. 29. **Grant Programs; Disabilities Grants**	23,770,000	24,770,000

(a) **Minnesota Organization on Fetal Alcohol Syndrome.** $500,000 in fiscal year 2018 and $500,000 in fiscal year 2019 are for a grant to the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). This is a onetime appropriation. Of this amount, MOFAS shall make grants to eligible regional collaboratives that fulfill the requirements in this paragraph. "Eligible regional collaboratives" means a partnership between at least one local government and at least one community-based organization and, where

available, a family home visiting program. For purposes of this paragraph, a local government includes a county or multicounty organization, a tribal government, a county-based purchasing entity, or a community health board. Eligible regional collaboratives must use grant funds to reduce the incidence of fetal alcohol syndrome disorders and other prenatal drug-related effects in children in Minnesota by identifying and serving pregnant women suspected of or known to use or abuse alcohol or other drugs. The eligible regional collaboratives must provide intensive services to chemically dependent women to increase positive birth outcomes. MOFAS must make grants to eligible regional collaboratives from both rural and urban areas. A grant recipient must report to the commissioner of human services annually by January 15 on the services and programs funded by the appropriation. The report must include measurable outcomes for the previous year, including the number of pregnant women served and the number of toxic-free babies born.

(b) **Services for Persons with Intellectual and Developmental Disabilities.** $143,000 in fiscal year 2018 and $143,000 in fiscal year 2019 are for a grant to an organization governed by persons with intellectual and developmental disabilities and administering a statewide network of disability groups to maintain and promote self-advocacy services and supports for persons with intellectual and developmental disabilities throughout the state.

Grant funds must be used for the following purposes:

(1) to maintain the infrastructure needed to train and support the activities of a statewide network of peer-to-peer mentors for persons with developmental disabilities, focused on building awareness of service options and advocacy skills necessary to move toward full inclusion in community life, including the development and delivery of the curriculum to support the peer-to-peer network;

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

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

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

(c) **Outreach to Persons in Institutional Settings.** $105,000 in fiscal year 2018 and $105,000 in fiscal year 2019 are for a grant to an organization governed by persons with intellectual and developmental disabilities and administering a statewide network of disability groups to be used for subgrants to organizations in Minnesota to conduct outreach to persons working and living in institutional settings to provide education and information about community options. Grant

funds must be used to deliver peer-led skill training sessions in six regions of the state to help persons with intellectual and developmental disabilities understand community service options related to:

(1) housing;

(2) employment;

(3) education;

(4) transportation;

(5) emerging service reform initiatives contained in the state's Olmstead plan; the Workforce Innovation and Opportunity Act, Public Law 113-128; and federal home and community-based services regulations; and

(6) connecting with individuals who can help persons with intellectual and developmental disabilities make an informed choice and plan for a transition in services.

(d) **Life Skills Training for Individuals with Autism Spectrum Disorder.** $250,000 in fiscal year 2018 and $250,000 in fiscal year 2019 are for a grant to an organization located in Richfield that provides life skills training to young adults with learning disabilities to meet the needs of individuals with autism spectrum disorder. This appropriation may be used to:

(1) create a best practices curriculum for serving individuals with autism spectrum disorder in residential placements with therapeutic programming; and

(2) expand facilities by adding safety features, living spaces, and academic areas.

Any unexpended balance in the first year is available in the second year.

(e) **Disability Waiver Rate System Transition Grants.** $2,000,000 in fiscal year 2018 and $3,000,000 in fiscal year 2019 are from the general fund for grants to home and community-based waiver services providers that will receive at least a ten-percent decrease in revenues due to the transition to rates calculated under Minnesota Statutes, section 256B.4914. Grants shall ensure ongoing access for individuals currently receiving these services and provide stability to provider organizations as they transition to new service delivery models. The base for fiscal year 2020 is $1,000,000. This is a onetime appropriation.

(f) **Base Level Adjustment.** The general fund base is $22,022,000 in fiscal year 2020 and $21,022,000 in fiscal year 2021.

Subd. 30. **Grant Programs; Adult Mental Health Grants**

	Appropriations by Fund	
General	88,626,000	83,949,000
Health Care Access	750,000	750,000
Lottery Prize	1,733,000	1,733,000

(a) **Mental Health Innovation Grant Program.** $4,000,000 in fiscal year 2018 is from the general fund for the mental health innovation grant program. This is a onetime appropriation and is available until June 30, 2021.

(b) **Housing Options for Persons with Serious Mental Illness.** $1,250,000 in fiscal year 2018 and $1,250,000 in fiscal year 2019 are from the general fund to the commissioner

for adult mental health grants under Minnesota Statutes, section 245.4661, subdivision 9, paragraph (a), clause (2), to support increased availability of housing options with supports for persons with serious mental illness. This is a onetime appropriation.

(c) **Assertive Community Treatment.** $500,000 in fiscal year 2018 and $500,000 in fiscal year 2019 are from the general fund to the commissioner for adult mental health grants under Minnesota Statutes, section 256B.0622, subdivision 12, to expand assertive community treatment services. This is a onetime appropriation.

(d) **Mental Health Crisis Services.** $1,000,000 in fiscal year 2018 and $1,000,000 in fiscal year 2019 are from the general fund to the commissioner for adult mental health grants under Minnesota Statutes, section 245.4661, and children's mental health grants under Minnesota Statutes, section 245.4889, to expand mental health crisis services, including:

(1) mobile crisis services;

(2) residential crisis services;

(3) colocation of mobile crisis services in urgent care clinics and psychiatric emergency departments; and

(4) development of co-responder mental health crisis response models.

This is a onetime appropriation.

(e) **Text Message Suicide Prevention and Mental Health Crisis Response Program.**

$657,000 in fiscal year 2018 is from the general fund for a grant to a nonprofit to make the text message suicide prevention and mental health crisis response program available statewide. This is a onetime appropriation. The nonprofit shall use grant funds to:

(1) operate the text message suicide prevention and mental health crisis response program statewide and provide a method of response that triages inquiries, provides immediate access to suicide prevention and crisis counseling over the telephone or via text messaging, and provides individual, family, or community education;

(2) connect individuals with trained crisis counselors and access to local resources, including referrals to community mental health options, emergency departments, and locally available mobile crisis teams, when appropriate;

(3) maximize availability of services and access across the state, in conjunction with other suicide prevention programs and services; and

(4) provide community education on the availability of the program and how to access the program.

Subd. 31. **Grant Programs; Child Mental Health Grants** 21,793,000 21,858,000

(a) **First Psychotic Episode Funding.** $750,000 in fiscal year 2018 and $750,000 in fiscal year 2019 are to fund grants under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (15). Funding shall be used to:

(1) provide intensive treatment and supports to adolescents and adults experiencing or at risk of a first psychotic episode. Intensive treatment and support includes medication management, psychoeducation for the individual and family, case management, employment supports, education supports, cognitive behavioral approaches, social skills training, peer support, crisis planning, and stress management. Projects must use all available funding streams;

(2) conduct outreach, training, and guidance to mental health and health care professionals, including postsecondary health clinics, on early psychosis symptoms, screening tools, and best practices; and

(3) ensure access to first psychotic episode psychosis services under this section, including ensuring access for individuals who live in rural areas. Funds may be used to pay for housing or travel or to address other barriers to individuals and their families participating in first psychotic episode services.

(b) **Children's School-Linked Mental Health Grants.** $2,000,000 in fiscal year 2018 and $2,000,000 in fiscal year 2019 are for children's school-linked mental health grants under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (8), to expand services to school districts or counties in which school-linked mental health services are not available and to fund transportation for children using school-linked mental health services when school is not in session. The

commissioner shall require grantees to use all available third-party reimbursement sources as a condition of the receipt of grant funds. For purposes of this appropriation, a third-party reimbursement source does not include a public school under Minnesota Statutes, section 120A.20, subdivision 1.

(c) **Respite Care Services.** $282,000 in fiscal year 2018 and $282,000 in fiscal year 2019 are for children's mental health grants under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (3), to provide respite care services to families of children with serious mental illness. This is a onetime appropriation.

(d) **Base Level Adjustment.** The general fund base is $21,576,000 in fiscal year 2020 and $21,576,000 in fiscal year 2021.

Subd. 32. **Grant Programs; Chemical Dependency Treatment Support Grants**	2,136,000	2,136,000

Problem Gambling. $225,000 in fiscal year 2018 and $225,000 in fiscal year 2019 are from the lottery prize fund for a grant to the state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research related to problem gambling.

Subd. 33. **Direct Care and Treatment - Generally**

(a) **Transfer Authority.** Money appropriated to budget activities under subdivisions 34, 35, 36, 37, and 38 may be transferred between

budget activities and between years of the biennium with the approval of the commissioner of management and budget.

(b) **Dedicated Receipts Available.** Of the revenue received under Minnesota Statutes, section 246.18, subdivision 8, paragraph (a), up to $1,000,000 each year is available for the purposes of Minnesota Statutes, section 246.18, subdivision 8, paragraph (b), clause (1); and up to $2,713,000 each year is available for the purposes of Minnesota Statutes, section 246.18, subdivision 8, paragraph (b), clause (2).

Subd. 34. **Direct Care and Treatment - Mental Health and Substance Abuse**	114,521,000	114,607,000

(a) **DCT Operating Adjustment (CARE).** $431,000 in fiscal year 2018 and $835,000 in fiscal year 2019 are from the general fund for Community Addiction Recover Enterprise (CARE) operating adjustments. The commissioner must transfer $431,000 in fiscal year 2018 and $835,000 in fiscal year 2019 to the enterprise fund for CARE.

(b) **Child and Adolescent Behavioral Health Services.** $405,000 in fiscal year 2018 and $491,000 in fiscal year 2019 are to continue to operate the child and adolescent behavioral health services program under Minnesota Statutes, section 246.014.

(c) **Base Level Adjustment.** The general fund base is $114,607,000 in fiscal year 2020 and $114,607,000 in fiscal year 2021.

Subd. 35. **Direct Care and Treatment - Community-Based Services**	15,298,000	15,298,000

Base Level Adjustment. The general fund base is $15,298,000 in fiscal year 2020 and $15,298,000 in fiscal year 2021.

Subd. 36. **Direct Care and Treatment - Forensic Services** 91,658,000 91,675,000

Base Level Adjustment. The general fund base is $91,675,000 in fiscal year 2020 and $91,675,000 in fiscal year 2021.

Subd. 37. **Direct Care and Treatment - Sex Offender Program** 86,731,000 86,731,000

Transfer Authority. Money appropriated for the Minnesota sex offender program may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

Subd. 38. **Direct Care and Treatment - Operations** 42,244,000 42,244,000

Base Level Adjustment. The general fund base is $42,244,000 in fiscal year 2020 and $42,244,000 in fiscal year 2021.

Subd. 39. **Technical Activities** 86,186,000 86,339,000

(a) This appropriation is from the federal TANF fund.

(b) **Base Level Adjustment.** The TANF fund appropriation is $86,346,000 in fiscal year 2020 and $86,355,000 in fiscal year 2021.

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$** **205,174,000** **$** **197,889,000**

Appropriations by Fund

	2018	2019
General	103,352,000	96,734,000
State Government Special Revenue	52,543,000	52,463,000
Health Care Access	37,566,000	36,979,000

Federal TANF	11,713,000	11,713,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Health Improvement**

Appropriations by Fund		
General	80,655,000	74,111,000
State Government Special Revenue	6,215,000	6,182,000
Health Care Access	37,566,000	36,979,000
Federal TANF	11,713,000	11,713,000

(a) **Palliative Care Advisory Council.** $44,000 in fiscal year 2018 and $44,000 in fiscal year 2019 are from the general fund for the Palliative Care Advisory Council under Minnesota Statutes, section 144.059.

(b) **Grants for Drug Deactivation and Disposal.** $500,000 in fiscal year 2018 and $500,000 in fiscal year 2019 are from the general fund for the commissioner to provide grants to pharmacists and other prescription drug dispensers, local public health and human services agencies, local law enforcement, health care providers, and other entities to purchase omni-degradable, at-home prescription drug deactivation and disposal products to assist the public in the disposal of prescription drugs in a safe, environmentally sound manner. A grant recipient must provide these deactivation and disposal products free of charge to members of the public. This is a onetime appropriation.

(c) **Opioid Abuse Prevention.** $1,000,000 in fiscal year 2018 is from the general fund for the commissioner to implement opioid abuse

prevention pilot projects and to contract with an accountable community for health for administrative and technical assistance and for an evaluation of the pilot projects. This is a onetime appropriation and is available through June 30, 2019.

(d) **Early Dental Disease Prevention Pilot Program.** $500,000 in fiscal year 2018 and $500,000 in fiscal year 2019 are from the general fund to implement a pilot program to increase awareness and encourage early preventive dental disease intervention and care for infants and toddlers.

(e) **TANF Appropriations.** (1) $1,156,000 of the TANF fund is appropriated each year of the biennium to the commissioner for family planning grants under Minnesota Statutes, section 145.925.

(2) $3,579,000 of the TANF fund is appropriated each year of the biennium to the commissioner for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1.

(3) $2,000,000 of the TANF fund is appropriated each year of the biennium to the commissioner for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7.

(4) $4,978,000 of the TANF fund is appropriated each year of the biennium to the

commissioner for the family home visiting grant program according to Minnesota Statutes, section 145A.17. $4,000,000 of the funding must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding must be distributed to tribal governments as provided in Minnesota Statutes, section 145A.14, subdivision 2a.

(5) The commissioner may use up to 6.23 percent of the funds appropriated each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

(f) **TANF Carryforward.** Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

(g) **Minnesota Biomedicine and Bioethics Innovation Grants.** $5,000,000 in fiscal year 2018 is from the general fund for Minnesota biomedicine and bioethics innovation grants under Minnesota Statutes, section 144.88. This is a onetime appropriation and is available until June 30, 2021.

(h) **Statewide Tobacco Quitline Service.** Of the health care access fund appropriation for the statewide health improvement program, $461,000 in fiscal year 2018 and $2,969,000 in fiscal year 2019 are for administering or contracting for the administration of the

statewide tobacco quitline service established under Minnesota Statutes, section 144.397.

(i) **Home and Community-Based Services Employee Scholarship Program.** $1,000,000 in fiscal year 2018 and $1,000,000 in fiscal year 2019 are from the general fund for the home and community-based services employee scholarship program under Minnesota Statutes, section 144.1503.

(j) **Senior Care Workforce Innovation Grant Program.** $1,000,000 in fiscal year 2018 and $1,000,000 in fiscal year 2019 are from the general fund for the senior care workforce innovation grant program under Minnesota Statutes, section 144.1504.

(k) **Primary Care and Mental Health Professions Clinical Training Expansion Grant Program.** $1,000,000 in fiscal year 2018 and $1,000,000 in fiscal year 2019 are from the general fund for the primary care and mental health professions clinical training expansion grant program under Minnesota Statutes, section 144.1505.

(l) **Physician Residency Expansion Grant Program.** $1,500,00 in fiscal year 2018 and $1,500,000 in fiscal 2019 are from the health care access fund for the physician residency expansion grant program under Minnesota Statutes, section 144.1506.

(m) **Comprehensive Advanced Life Support Educational Program.** $100,000 in fiscal year 2018 and $100,000 in fiscal year 2019 are from the general fund for the comprehensive advanced life support

educational program under Minnesota Statutes, section 144.6062. This is a onetime appropriation.

(n) **Advanced Care Planning.** $500,000 in fiscal year 2018 and $500,000 in fiscal year 2019 are from the general fund for a grant to a statewide advanced care planning resource organization that has expertise in convening and coordinating community-based strategies to encourage individuals, families, caregivers, and health care providers to begin conversations regarding end-of-life care choices that express an individual's health care values and preferences and are based on informed health care decisions.

(o) **Plan and Report on Safe Harbor for All Model.** $73,000 in fiscal year 2018 is from the general fund to develop a statewide sex trafficking victims strategic plan and report. This is a onetime appropriation.

(p) **Safe Harbor Program.** $420,000 in fiscal year 2018 and $420,000 in fiscal year 2019 are from the general fund for trauma-informed, culturally specific services for sexually exploited youth 24 years of age or younger and for training, technical assistance, protocol implementation, and evaluation activities related to the safe harbor program. In funding services and activities under this paragraph, the commissioner of health shall emphasize activities that promote capacity-building and development of resources in greater Minnesota. This is a onetime appropriation.

(q) **Youth Sports Concussion Working Group and Brain Health Pilot Programs.**

$450,000 in fiscal year 2018 is from the general fund for the youth sports concussion working group and brain health pilot programs. This is a onetime appropriation. Of this appropriation:

(1) $150,000 is for the youth sports concussion working group, including any required incidence research; and

(2) $300,000 is for the brain health pilot programs.

(r) **Base Level Adjustments.** The general fund base is $72,541,000 in fiscal year 2020 and $72,591,000 in fiscal year 2021. The health care access fund base is $37,579,000 in fiscal year 2020 and $36,979,000 in fiscal year 2021.

Subd. 3. **Health Protection**

Appropriations by Fund		
General	14,552,000	14,478,000
State Government Special Revenue	46,328,000	46,281,000

(a) **Prescribed Pediatric Extended Care Center Licensure Activities.** $7,000 in fiscal year 2018 and $13,000 in fiscal year 2019 are from the state government special revenue fund for licensure of prescribed pediatric extended care centers under Minnesota Statutes, chapter 144H.

(b) **Vulnerable Adults in Health Care Settings.** $633,000 in fiscal year 2018 and $559,000 in fiscal year 2019 are from the general fund for regulating health care and home care settings.

(c) **Base Level Adjustment.** The general fund base is $14,867,000 in fiscal year 2020 and

$14,777,000 in fiscal year 2021. The state government special revenue fund base is $46,266,000 in fiscal year 2020 and $46,266,000 in fiscal year 2021.

Subd. 4. **Health Operations**

	Appropriations by Fund	
General	8,145,000	8,145,000

Sec. 4. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation**	**$ 24,979,000**	**$ 23,172,000**

This appropriation is from the state government special revenue fund. The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Board of Chiropractic Examiners**	565,000	571,000

Base Level Adjustment. The base is $576,000 in fiscal year 2020 and $576,000 in fiscal year 2021.

Subd. 3. **Board of Dentistry**	1,396,000	1,408,000
Subd. 4. **Board of Dietetics and Nutrition Practice**	130,000	132,000
Subd. 5. **Board of Marriage and Family Therapy**	360,000	357,000

Base Level Adjustment. The base is $360,000 in fiscal year 2020 and $362,000 in fiscal year 2021.

Subd. 6. **Board of Medical Practice**	5,207,000	5,243,000

This appropriation includes $964,000 in fiscal year 2018 and $964,000 in fiscal year 2019 for the health professional services program. The base for this program is $924,000 in fiscal year 2020 and $924,000 in fiscal year 2021.

Base Level Adjustment. The base is $5,205,000 in fiscal year 2020 and $5,205,000 in fiscal year 2021.

Subd. 7. **Board of Nursing**	6,380,000	4,783,000
Subd. 8. **Board of Nursing Home Administrators**	3,397,000	3,202,000

(a) **Administrative Services Unit - Operating Costs.** Of this appropriation, $2,260,000 in fiscal year 2018 and $2,287,000 in fiscal year 2019 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services it performs for other agencies.

(b) **Administrative Services Unit - Volunteer Health Care Provider Program.** Of this appropriation, $150,000 in fiscal year 2018 and $150,000 in fiscal year 2019 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

(c) **Administrative Services Unit - Retirement Costs.** Of this appropriation, $378,000 in fiscal year 2019 is a onetime appropriation to the administrative services unit to pay for the retirement costs of health-related board employees. This funding may be transferred to the health board incurring retirement costs. Any board that has an unexpended balance for an amount transferred under this paragraph shall transfer the unexpended amount to the administrative services unit. These funds are available either year of the biennium.

(d) **Administrative Services Unit - Health-Related Licensing Boards Operating Costs.** Of this appropriation, $194,000 in fiscal year 2018 and $350,000 in fiscal year

2019 shall be transferred to the health-related boards funded under this section for operating costs. The administrative services unit shall determine transfer amounts in consultation with the health-related boards funded under this section.

(e) **Administrative Services Unit - Contested Cases and Other Legal Proceedings.** Of this appropriation, $200,000 in fiscal year 2018 and $200,000 in fiscal year 2019 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification by a health-related board to the administrative services unit that costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of management and budget. The commissioner of management and budget must require any board that has an unexpended balance for an amount transferred under this paragraph to transfer the unexpended amount to the administrative services unit to be deposited in the state government special revenue fund.

Subd. 9. **Board of Optometry**	156,000	157,000
Subd. 10. **Board of Pharmacy**	3,124,000	3,164,000

Base Level Adjustment. The base is $3,189,000 in fiscal year 2020 and $3,226,000 in fiscal year 2021.

Subd. 11. **Board of Physical Therapy** 507,000 508,000

Base Level Adjustment. The base is $510,000 in fiscal year 2020 and $512,000 in fiscal year 2021.

Subd. 12. **Board of Podiatric Medicine** 198,000 198,000

Subd. 13. **Board of Psychology** 1,220,000 1,240,000

Base Level Adjustment. The base is $1,247,000 in fiscal year 2020 and $1,247,000 in fiscal year 2021.

Subd. 14. **Board of Social Work** 1,254,000 1,246,000

Base Level Adjustment. The base is $1,248,000 in fiscal year 2020 and $1,250,000 in fiscal year 2021.

Subd. 15. **Board of Veterinary Medicine** 314,000 320,000

Base Level Adjustment. The base is $327,000 in fiscal year 2020 and $333,000 in fiscal year 2021.

Subd. 16. **Board of Behavioral Health and Therapy** 771,000 643,000

Sec. 5. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD** **$ 4,509,000 $ 4,438,000**

(a) **Cooper/Sams Volunteer Ambulance Program.** $1,300,000 in fiscal year 2018 and $1,300,000 in fiscal year 2019 are for the Cooper/Sams volunteer ambulance program under Minnesota Statutes, section 144E.40. The base for this program is $700,000 in fiscal year 2020 and $700,000 in fiscal year 2021.

(1) Of this amount, $1,211,000 in fiscal year 2018 and $1,211,000 in fiscal year 2019 are for the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40. The base for this

program is $611,000 in fiscal year 2020 and $611,000 in fiscal year 2021.

(2) Of this amount, $89,000 in fiscal year 2018 and $89,000 in fiscal year 2019 are for the operations of the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(b) **EMSRB Board Operations.** $1,360,000 in fiscal year 2018 and $1,360,000 in fiscal year 2019 are for board operations.

(c) **Base Level Adjustment.** The base is $3,840,000 in fiscal year 2020 and $3,840,000 in fiscal year 2021.

(d) **Regional Grants.** $585,000 in fiscal year 2018 and $585,000 in fiscal year 2019 are for regional emergency medical services programs, to be distributed equally to the eight emergency medical service regions under Minnesota Statutes, section 144E.50.

(e) **Ambulance Training Grant.** $361,000 in fiscal year 2018 and $361,000 in fiscal year 2019 are for training grants under Minnesota Statutes, section 144E.35.

Sec. 6. **COUNCIL ON DISABILITY** **$ 1,002,000 $ 1,002,000**

Base Level Adjustment. The base is $966,000 in fiscal year 2020 and $968,000 in fiscal year 2021.

Sec. 7. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 2,407,000 $ 2,427,000**

Department of Psychiatry Monitoring. $100,000 in fiscal year 2018 and $100,000 in fiscal year 2019 are for monitoring the

Department of Psychiatry at the University of Minnesota.

Sec. 8. **OMBUDSPERSONS FOR FAMILIES** **$ 543,000 $ 551,000**

Sec. 9. **COMMISSIONER OF COMMERCE** **$ 1,194,000 $ 1,194,000**

Sec. 10. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2019, within fiscal years among the MFIP, general assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental aid, and group residential housing programs, the entitlement portion of Northstar Care for Children under Minnesota Statutes, chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance and Policy Committee, the senate Human Services Reform Finance and Policy Committee, and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Departments of Health and Human Services as the commissioners consider necessary, with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance and Policy Committee, the senate Human Services Reform Finance and Policy Committee, and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Sec. 11. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioners of health and human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 12. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2019, unless a different expiration date is explicit.

Sec. 13. **EFFECTIVE DATE.**

This article is effective July 1, 2017, unless a different effective date is specified.

APPENDIX
Article locations in UES0800-1

62V.01 TITLE.

This chapter may be cited as the "MNsure Act."

62V.02 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of this chapter, the following terms have the meanings given.

Subd. 2. **Board.** "Board" means the Board of Directors of MNsure specified in section 62V.04.

Subd. 3. **Dental plan.** "Dental plan" has the meaning defined in section 62Q.76, subdivision 3.

Subd. 4. **Health plan.** "Health plan" means a policy, contract, certificate, or agreement defined in section 62A.011, subdivision 3.

Subd. 5. **Health carrier.** "Health carrier" has the meaning defined in section 62A.011.

Subd. 6. **Individual market.** "Individual market" means the market for health insurance coverage offered to individuals.

Subd. 7. **Insurance producer.** "Insurance producer" has the meaning defined in section 60K.31.

Subd. 8. **MNsure.** "MNsure" means the state health benefit exchange as described in section 1311 of the federal Patient Protection and Affordable Care Act, Public Law 111-148, and further defined through amendments to the act and regulations issued under the act.

Subd. 9. **Navigator.** "Navigator" has the meaning described in section 1311(i) of the federal Patient Protection and Affordable Care Act, Public Law 111-148, and further defined through amendments to the act and regulations issued under the act.

Subd. 10. **Public health care program.** "Public health care program" means any public health care program administered by the commissioner of human services.

Subd. 11. **Qualified health plan.** "Qualified health plan" means a health plan that meets the definition in section 1301(a) of the Affordable Care Act, Public Law 111-148, and has been certified by the board in accordance with section 62V.05, subdivision 5, to be offered through MNsure.

Subd. 12. **Small group market.** "Small group market" means the market for health insurance coverage offered to small employers as defined in section 62L.02, subdivision 26.

Subd. 13. **Web site.** "Web site" means a site maintained on the World Wide Web by MNsure that allows for access to information and services provided by MNsure.

62V.03 MNSURE; ESTABLISHMENT.

Subdivision 1. **Creation.** MNsure is created as a board under section 15.012, paragraph (a), to:

(1) promote informed consumer choice, innovation, competition, quality, value, market participation, affordability, suitable and meaningful choices, health improvement, care management, reduction of health disparities, and portability of health plans;

(2) facilitate and simplify the comparison, choice, enrollment, and purchase of health plans for individuals purchasing in the individual market through MNsure and for employees and employers purchasing in the small group market through MNsure;

(3) assist small employers with access to small business health insurance tax credits and to assist individuals with access to public health care programs, premium assistance tax credits and cost-sharing reductions, and certificates of exemption from individual responsibility requirements;

(4) facilitate the integration and transition of individuals between public health care programs and health plans in the individual or group market and develop processes that, to the maximum extent possible, provide for continuous coverage; and

(5) establish and modify as necessary a name and brand for MNsure based on market studies that show maximum effectiveness in attracting the uninsured and motivating them to take action.

Subd. 2. **Application of other law.** (a) MNsure must be reviewed by the legislative auditor under section 3.971. The legislative auditor shall audit the books, accounts, and affairs of MNsure once each year or less frequently as the legislative auditor's funds and personnel permit. Upon the audit of the financial accounts and affairs of MNsure, MNsure is liable to the state for the total cost and expenses of the audit, including the salaries paid to the examiners while actually engaged in making the examination. The legislative auditor may bill MNsure either monthly or at the completion of the audit. All collections received for the audits must be deposited in the general

fund and are appropriated to the legislative auditor. Pursuant to section 3.97, subdivision 3a, the Legislative Audit Commission is requested to direct the legislative auditor to report by March 1, 2014, to the legislature on any duplication of services that occurs within state government as a result of the creation of MNsure. The legislative auditor may make recommendations on consolidating or eliminating any services deemed duplicative. The board shall reimburse the legislative auditor for any costs incurred in the creation of this report.

(b) Board members of MNsure are subject to sections 10A.07 and 10A.09. Board members and the personnel of MNsure are subject to section 10A.071.

(c) All meetings of the board and of the Minnesota Eligibility System Executive Steering Committee established under section 62V.055 shall comply with the open meeting law in chapter 13D.

(d) The board and the Web site are exempt from chapter 60K. Any employee of MNsure who sells, solicits, or negotiates insurance to individuals or small employers must be licensed as an insurance producer under chapter 60K.

(e) Section 3.3005 applies to any federal funds received by MNsure.

(f) A MNsure decision that requires a vote of the board, other than a decision that applies only to hiring of employees or other internal management of MNsure, is an "administrative action" under section 10A.01, subdivision 2.

Subd. 3. **Continued operation of a private marketplace.** (a) Nothing in this chapter shall be construed to prohibit: (1) a health carrier from offering outside of MNsure a health plan to a qualified individual or qualified employer; and (2) a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of MNsure.

(b) Nothing in this chapter shall be construed to restrict the choice of a qualified individual to enroll or not enroll in a qualified health plan or to participate in MNsure. Nothing in this chapter shall be construed to compel an individual to enroll in a qualified health plan or to participate in MNsure.

(c) For purposes of this subdivision, "qualified individual" and "qualified employer" have the meanings given in section 1312 of the Affordable Care Act, Public Law 111-148, and further defined through amendments to the act and regulations issued under the act.

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.

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.05 RESPONSIBILITIES AND POWERS OF MNSURE.

Subdivision 1. **General.** (a) The board shall operate MNsure according to this chapter and applicable state and federal law.

(b) The board has the power to:

(1) employ personnel and delegate administrative, operational, and other responsibilities to the director and other personnel as deemed appropriate by the board. This authority is subject to chapters 43A and 179A. The director and managerial staff of MNsure shall serve in the unclassified service and shall be governed by a compensation plan prepared by the board, submitted to the commissioner of management and budget for review and comment within 14 days of its receipt, and approved by the Legislative Coordinating Commission and the legislature under section 3.855, except that section 15A.0815, subdivision 5, paragraph (e), shall not apply;

(2) establish the budget of MNsure;

(3) seek and accept money, grants, loans, donations, materials, services, or advertising revenue from government agencies, philanthropic organizations, and public and private sources to fund the operation of MNsure. No health carrier or insurance producer shall advertise on MNsure;

(4) contract for the receipt and provision of goods and services;

(5) enter into information-sharing agreements with federal and state agencies and other entities, provided the agreements include adequate protections with respect to the confidentiality and integrity of the information to be shared, and comply with all applicable state and federal laws, regulations, and rules, including the requirements of section 62V.06; and

(6) exercise all powers reasonably necessary to implement and administer the requirements of this chapter and the Affordable Care Act, Public Law 111-148.

(c) The board shall establish policies and procedures to gather public comment and provide public notice in the State Register.

(d) Within 180 days of enactment, the board shall establish bylaws, policies, and procedures governing the operations of MNsure in accordance with this chapter.

Subd. 2. **Operations funding.** (a) Prior to January 1, 2015, MNsure shall retain or collect up to 1.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the cash reserves of MNsure, but the amount collected shall not exceed a dollar amount equal to 25 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

(b) Beginning January 1, 2015, MNsure shall retain or collect up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operations of MNsure, but the amount collected shall not exceed a dollar amount equal to 50 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

(c) Beginning January 1, 2016, MNsure shall retain or collect up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operations of MNsure, but the amount collected may never exceed a dollar amount greater than 100 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

(d) For fiscal years 2014 and 2015, the commissioner of management and budget is authorized to provide cash flow assistance of up to $20,000,000 from the special revenue fund or the statutory general fund under section 16A.671, subdivision 3, paragraph (a), to MNsure. Any funds provided under this paragraph shall be repaid, with interest, by June 30, 2015.

(e) Funding for the operations of MNsure shall cover any compensation provided to navigators participating in the navigator program.

Subd. 3. **Insurance producers.** (a) By April 30, 2013, the board, in consultation with the commissioner of commerce, shall establish certification requirements that must be met by insurance producers in order to assist individuals and small employers with purchasing coverage through MNsure. Prior to January 1, 2015, the board may amend the requirements, only if necessary, due to a change in federal rules.

(b) Certification requirements shall not exceed the requirements established under Code of Federal Regulations, title 45, part 155.220. Certification shall include training on health plans available through MNsure, available tax credits and cost-sharing arrangements, compliance with privacy and security standards, eligibility verification processes, online enrollment tools, and basic information on available public health care programs. Training required for certification under this

subdivision shall qualify for continuing education requirements for insurance producers required under chapter 60K, and must comply with course approval requirements under chapter 45.

(c) Producer compensation shall be established by health carriers that provide health plans through MNsure. The structure of compensation to insurance producers must be similar for health plans sold through MNsure and outside MNsure.

(d) Any insurance producer compensation structure established by a health carrier for the small group market must include compensation for defined contribution plans that involve multiple health carriers. The compensation offered must be commensurate with other small group market defined health plans.

(e) Any insurance producer assisting an individual or small employer with purchasing coverage through MNsure must disclose, orally and in writing, to the individual or small employer at the time of the first solicitation with the prospective purchaser the following:

(1) the health carriers and qualified health plans offered through MNsure that the producer is authorized to sell, and that the producer may not be authorized to sell all the qualified health plans offered through MNsure;

(2) that the producer may be receiving compensation from a health carrier for enrolling the individual or small employer into a particular health plan; and

(3) that information on all qualified health plans offered through MNsure is available through the MNsure Web site.

For purposes of this paragraph, "solicitation" means any contact by a producer, or any person acting on behalf of a producer made for the purpose of selling or attempting to sell coverage through MNsure. If the first solicitation is made by telephone, the disclosures required under this paragraph need not be made in writing, but the fact that disclosure has been made must be acknowledged on the application.

(f) Beginning January 15, 2015, each health carrier that offers or sells qualified health plans through MNsure shall report in writing to the board and the commissioner of commerce the compensation and other incentives it offers or provides to insurance producers with regard to each type of health plan the health carrier offers or sells both inside and outside of MNsure. Each health carrier shall submit a report annually and upon any change to the compensation or other incentives offered or provided to insurance producers.

(g) Nothing in this chapter shall prohibit an insurance producer from offering professional advice and recommendations to a small group purchaser based upon information provided to the producer.

(h) An insurance producer that offers health plans in the small group market shall notify each small group purchaser of which group health plans qualify for Internal Revenue Service approved section 125 tax benefits. The insurance producer shall also notify small group purchasers of state law provisions that benefit small group plans when the employer agrees to pay 50 percent or more of its employees' premium. Individuals who are eligible for cost-effective medical assistance will count toward the 75 percent participation requirement in section 62L.03, subdivision 3.

(i) Nothing in this subdivision shall be construed to limit the licensure requirements or regulatory functions of the commissioner of commerce under chapter 60K.

Subd. 4. **Navigator; in-person assisters; call center.** (a) The board shall establish policies and procedures for the ongoing operation of a navigator program, in-person assister program, call center, and customer service provisions for MNsure to be implemented beginning January 1, 2015.

(b) Until the implementation of the policies and procedures described in paragraph (a), the following shall be in effect:

(1) the navigator program shall be met by section 256.962;

(2) entities eligible to be navigators, including entities defined in Code of Federal Regulations, title 45, part 155.210 (c)(2), may serve as in-person assisters;

(3) the board shall establish requirements and compensation for the navigator program and the in-person assister program by April 30, 2013. Compensation for navigators and in-person assisters must take into account any other compensation received by the navigator or in-person assister for conducting the same or similar services; and

(4) call center operations shall utilize existing state resources and personnel, including referrals to counties for medical assistance.

(c) The board shall establish a toll-free number for MNsure and may hire and contract for additional resources as deemed necessary.

(d) The navigator program and in-person assister program must meet the requirements of section 1311(i) of the Affordable Care Act, Public Law 111-148. In establishing training standards for the navigators and in-person assisters, the board must ensure that all entities and individuals carrying out navigator and in-person assister functions have training in the needs of underserved

and vulnerable populations; eligibility and enrollment rules and procedures; the range of available public health care programs and qualified health plan options offered through MNsure; and privacy and security standards. For calendar year 2014, the commissioner of human services shall ensure that the navigator program under section 256.962 provides application assistance for both qualified health plans offered through MNsure and public health care programs.

(e) The board must ensure that any information provided by navigators, in-person assisters, the call center, or other customer assistance portals be accessible to persons with disabilities and that information provided on public health care programs include information on other coverage options available to persons with disabilities.

Subd. 5. **Health carrier and health plan requirements; participation.** (a) Beginning January 1, 2015, the board may establish certification requirements for health carriers and health plans to be offered through MNsure that satisfy federal requirements under section 1311(c)(1) of the Affordable Care Act, Public Law 111-148.

(b) Paragraph (a) does not apply if by June 1, 2013, the legislature enacts regulatory requirements that:

(1) apply uniformly to all health carriers and health plans in the individual market;

(2) apply uniformly to all health carriers and health plans in the small group market; and

(3) satisfy minimum federal certification requirements under section 1311(c)(1) of the Affordable Care Act, Public Law 111-148.

(c) In accordance with section 1311(e) of the Affordable Care Act, Public Law 111-148, the board shall establish policies and procedures for certification and selection of health plans to be offered as qualified health plans through MNsure. The board shall certify and select a health plan as a qualified health plan to be offered through MNsure, if:

(1) the health plan meets the minimum certification requirements established in paragraph (a) or the market regulatory requirements in paragraph (b);

(2) the board determines that making the health plan available through MNsure is in the interest of qualified individuals and qualified employers;

(3) the health carrier applying to offer the health plan through MNsure also applies to offer health plans at each actuarial value level and service area that the health carrier currently offers in the individual and small group markets; and

(4) the health carrier does not apply to offer health plans in the individual and small group markets through MNsure under a separate license of a parent organization or holding company under section 60D.15, that is different from what the health carrier offers in the individual and small group markets outside MNsure.

(d) In determining the interests of qualified individuals and employers under paragraph (c), clause (2), the board may not exclude a health plan for any reason specified under section 1311(e)(1)(B) of the Affordable Care Act, Public Law 111-148. The board may consider:

(1) affordability;

(2) quality and value of health plans;

(3) promotion of prevention and wellness;

(4) promotion of initiatives to reduce health disparities;

(5) market stability and adverse selection;

(6) meaningful choices and access;

(7) alignment and coordination with state agency and private sector purchasing strategies and payment reform efforts; and

(8) other criteria that the board determines appropriate.

(e) For qualified health plans offered through MNsure on or after January 1, 2015, the board shall establish policies and procedures under paragraphs (c) and (d) for selection of health plans to be offered as qualified health plans through MNsure by February 1 of each year, beginning February 1, 2014. The board shall consistently and uniformly apply all policies and procedures and any requirements, standards, or criteria to all health carriers and health plans. For any policies, procedures, requirements, standards, or criteria that are defined as rules under section 14.02, subdivision 4, the board may use the process described in subdivision 9.

(f) For 2014, the board shall not have the power to select health carriers and health plans for participation in MNsure. The board shall permit all health plans that meet the certification requirements under section 1311(c)(1) of the Affordable Care Act, Public Law 111-148, to be offered through MNsure.

(g) Under this subdivision, the board shall have the power to verify that health carriers and health plans are properly certified to be eligible for participation in MNsure.

(h) The board has the authority to decertify health carriers and health plans that fail to maintain compliance with section 1311(c)(1) of the Affordable Care Act, Public Law 111-148.

(i) For qualified health plans offered through MNsure beginning January 1, 2015, health carriers must use the most current addendum for Indian health care providers approved by the Centers for Medicare and Medicaid Services and the tribes as part of their contracts with Indian health care providers. MNsure shall comply with all future changes in federal law with regard to health coverage for the tribes.

Subd. 6. **Appeals.** (a) The board may conduct hearings, appoint hearing officers, and recommend final orders related to appeals of any MNsure determinations, except for those determinations identified in paragraph (d). An appeal by a health carrier regarding a specific certification or selection determination made by MNsure under subdivision 5 must be conducted as a contested case proceeding under chapter 14, with the report or order of the administrative law judge constituting the final decision in the case, subject to judicial review under sections 14.63 to 14.69. For other appeals, the board shall establish hearing processes which provide for a reasonable opportunity to be heard and timely resolution of the appeal and which are consistent with the requirements of federal law and guidance. An appealing party may be represented by legal counsel at these hearings, but this is not a requirement.

(b) MNsure may establish service-level agreements with state agencies to conduct hearings for appeals. Notwithstanding section 471.59, subdivision 1, a state agency is authorized to enter into service-level agreements for this purpose with MNsure.

(c) For proceedings under this subdivision, MNsure may be represented by an attorney who is an employee of MNsure.

(d) This subdivision does not apply to appeals of determinations where a state agency hearing is available under section 256.045.

(e) An appellant aggrieved by an order of MNsure issued in an eligibility appeal, as defined in Minnesota Rules, part 7700.0101, may appeal the order to the district court of the appellant's county of residence by serving a written copy of a notice of appeal upon MNsure and any other adverse party of record within 30 days after the date MNsure issued the order, the amended order, or order affirming the original order, and by filing the original notice and proof of service with the court administrator of the district court. Service may be made personally or by mail; service by mail is complete upon mailing; no filing fee shall be required by the court administrator in appeals taken pursuant to this subdivision. MNsure shall furnish all parties to the proceedings with a copy of the decision and a transcript of any testimony, evidence, or other supporting papers from the hearing held before the appeals examiner within 45 days after service of the notice of appeal.

(f) Any party aggrieved by the failure of an adverse party to obey an order issued by MNsure may compel performance according to the order in the manner prescribed in sections 586.01 to 586.12.

(g) Any party may obtain a hearing at a special term of the district court by serving a written notice of the time and place of the hearing at least ten days prior to the date of the hearing. The court may consider the matter in or out of chambers, and shall take no new or additional evidence unless it determines that such evidence is necessary for a more equitable disposition of the appeal.

(h) Any party aggrieved by the order of the district court may appeal the order as in other civil cases. No costs or disbursements shall be taxed against any party nor shall any filing fee or bond be required of any party.

(i) If MNsure or district court orders eligibility for qualified health plan coverage through MNsure, or eligibility for federal advance payment of premium tax credits or cost-sharing reductions contingent upon full payment of respective premiums, the premiums must be paid or provided pending appeal to the district court, Court of Appeals, or Supreme Court. Provision of eligibility by MNsure pending appeal does not render moot MNsure's position in a court of law.

Subd. 7. **Agreements; consultation.** (a) The board shall:

(1) establish and maintain an agreement with the commissioner of human services for cost allocation and services regarding eligibility determinations and enrollment for public health care programs that use a modified adjusted gross income standard to determine program eligibility. The board may establish and maintain an agreement with the commissioner of human services for other services;

(2) establish and maintain an agreement with the commissioners of commerce and health for services regarding enforcement of MNsure certification requirements for health plans and dental plans offered through MNsure. The board may establish and maintain agreements with the commissioners of commerce and health for other services; and

(3) establish interagency agreements to transfer funds to other state agencies for their costs related to implementing and operating MNsure, excluding medical assistance allocatable costs.

(b) The board shall consult with the commissioners of commerce and health regarding the operations of MNsure.

(c) The board shall consult with Indian tribes and organizations regarding the operation of MNsure.

(d) Beginning March 15, 2016, and each March 15 thereafter, the board shall submit a report to the chairs and ranking minority members of the committees in the senate and house of representatives with primary jurisdiction over commerce, health, and human services on all the agreements entered into with the chief information officer of the Office of MN.IT Services, or the commissioners of human services, health, or commerce in accordance with this subdivision. The report shall include the agency in which the agreement is with; the time period of the agreement; the purpose of the agreement; and a summary of the terms of the agreement. A copy of the agreement must be submitted to the extent practicable.

Subd. 8. **Rulemaking.** The board may adopt rules to implement any provisions in this chapter using the expedited rulemaking process in section 14.389.

Subd. 9. **Dental plans.** (a) The provisions of this section that apply to health plans shall apply to dental plans offered as stand-alone dental plans through MNsure, to the extent practicable.

(b) A stand-alone dental plan offered through MNsure must meet all certification requirements under section 1311(c)(1) of the Affordable Care Act, Public Law 111-148, that are applicable to health plans, except for certification requirements that cannot be met because the dental plan only covers dental benefits.

Subd. 10. **Limitations; risk-bearing.** (a) The board shall not bear insurance risk or enter into any agreement with health care providers to pay claims.

(b) Nothing in this subdivision shall prevent MNsure from providing insurance for its employees.

Subd. 11. **Prohibition on other product lines.** MNsure is prohibited from certifying, selecting, or offering products and policies of coverage that do not meet the definition of health plan or dental plan as provided in section 62V.02.

Subd. 12. **Reports on interagency agreements and intra-agency transfers.** The MNsure Board shall provide quarterly reports to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on:

(1) interagency agreements or service-level agreements and any renewals or extensions of existing interagency or service-level agreements with a state department under section 15.01, state agency under section 15.012, or the Office of MN.IT Services, with a value of more than $100,000, or related agreements with the same department or agency with a cumulative value of more than $100,000; and

(2) transfers of appropriations of more than $100,000 between accounts within or between agencies.

The report must include the statutory citation authorizing the agreement, transfer or dollar amount, purpose, and effective date of the agreement, the duration of the agreement, and a copy of the agreement.

62V.051 MNSURE; CONSUMER RETROACTIVE APPOINTMENT OF A NAVIGATOR OR PRODUCER PERMITTED.

Notwithstanding any other law or rule to the contrary, for up to six months after the effective date of the qualified health plan, MNsure must permit a qualified health plan policyholder, who has not designated a navigator or an insurance producer, to retroactively appoint a navigator or insurance producer. MNsure must provide notice of the retroactive appointment to the health carrier. The health carrier must retroactively pay commissions to the insurance producer if the producer can demonstrate that they were certified by MNsure at the time of the original enrollment, were appointed by the selected health carrier at the time of the enrollment, and that an agent of record agreement was executed prior to or at the time of the effective date of the policy. MNsure must adopt a standard form of agent of record agreement for purposes of this section.

62V.055 MINNESOTA ELIGIBILITY SYSTEM EXECUTIVE STEERING COMMITTEE.

Subdivision 1. **Definition; Minnesota eligibility system.** For purposes of this section, "Minnesota eligibility system" means the system that supports eligibility determinations using a modified adjusted gross income methodology for medical assistance under section 256B.056, subdivision 1a, paragraph (b), clause (1); MinnesotaCare under chapter 256L; and qualified health plan enrollment under section 62V.05, subdivision 5, paragraph (c).

Subd. 2. **Establishment; committee membership; costs.** (a) The Minnesota Eligibility System Executive Steering Committee is established to provide recommendations to the MNsure

board, the commissioner of human services, and the commissioner of MN.IT services on the governance, administration, and business operations of the Minnesota eligibility system. The steering committee shall be composed of:

(1) two members appointed by the commissioner of human services;

(2) two members appointed by the board;

(3) two members appointed jointly by the Association of Minnesota Counties, the Minnesota Inter-County Association, and the Minnesota Association of County Social Service Administrators. One member appointed under this clause shall represent counties within the seven-county metropolitan area, and one member shall represent counties outside the seven-county metropolitan area; and

(4) two nonvoting members appointed by the commissioner of MN.IT services.

(b) One member appointed by the commissioner of human services and one member appointed by the commissioner of MN.IT services shall serve as co-chairpersons for the steering committee.

(c) Steering committee costs must be paid from the budgets of the Department of Human Services, the Office of MN.IT Services, and MNsure.

Subd. 3. **Duties.** The Minnesota Eligibility System Executive Steering Committee shall provide recommendations on an overall governance structure for the Minnesota eligibility system and the ongoing administration and business operations of the Minnesota eligibility system. The steering committee shall make recommendations on setting system goals and priorities, allocating the system's resources, making major system decisions, and tracking total funding and expenditures for the system from all sources. The steering committee shall also report to the Legislative Oversight Committee on a quarterly basis on Minnesota eligibility system funding and expenditures, including amounts received in the most recent quarter by funding source and expenditures made in the most recent quarter by funding source.

Subd. 4. **Meetings.** (a) All meetings of the steering committee must:

(1) be held in the State Office Building, the Minnesota Senate Building, or when approved by the Legislative Oversight Committee, another public location with the capacity to live stream steering committee meetings; and

(2) whenever possible, be made available on a Web site for live audio or video streaming and be archived on a Web site for playback at a later time.

(b) The steering committee must:

(1) as part of every steering committee meeting, provide the opportunity for oral and written public testimony and comments on steering committee recommendations for the governance, administration, and business operations of the Minnesota eligibility system; and

(2) provide documents under discussion or review by the steering committee to be electronically posted on MNsure's Web site. Documents must be provided and posted prior to the meeting at which the documents are scheduled for review or discussion.

(c) All votes of the steering committee must be recorded, with each member's vote identified.

Subd. 5. **Administrative structure.** The Office of MN.IT Services shall be responsible for the design, build, maintenance, operation, and upgrade of the information technology for the Minnesota eligibility system. In carrying out its duties, the office shall consider recommendations made by the steering committee.

62V.06 DATA PRACTICES.

Subdivision 1. **Applicability.** MNsure is a state agency for purposes of the Minnesota Government Data Practices Act and is subject to all provisions of chapter 13, in addition to the requirements contained in this section.

Subd. 2. **Definitions.** As used in this section:

(1) "individual" means an individual according to section 13.02, subdivision 8, but does not include a vendor of services; and

(2) "participating" means that an individual, employee, or employer is seeking, or has sought an eligibility determination, enrollment processing, or premium processing through MNsure.

Subd. 3. **General data classifications.** The following data collected, created, or maintained by MNsure are classified as private data on individuals, as defined in section 13.02, subdivision 12, or nonpublic data, as defined in section 13.02, subdivision 9:

(1) data on any individual participating in MNsure;

(2) data on any individuals participating in MNsure as employees of an employer participating in MNsure; and

(3) data on employers participating in MNsure.

Subd. 4. **Application and certification data.** (a) Data submitted by an insurance producer in an application for certification to sell a health plan through MNsure, or submitted by an applicant seeking permission or a commission to act as a navigator or in-person assister, are classified as follows:

(1) at the time the application is submitted, all data contained in the application are private data, as defined in section 13.02, subdivision 12, or nonpublic data as defined in section 13.02, subdivision 9, except that the name of the applicant is public; and

(2) upon a final determination related to the application for certification by MNsure, all data contained in the application are public, with the exception of trade secret data as defined in section 13.37.

(b) Data created or maintained by a government entity as part of the evaluation of an application are protected nonpublic data, as defined in section 13.02, subdivision 13, until a final determination as to certification is made and all rights of appeal have been exhausted. Upon a final determination and exhaustion of all rights of appeal, these data are public, with the exception of trade secret data as defined in section 13.37 and data subject to attorney-client privilege or other protection as provided in section 13.393.

(c) If an application is denied, the public data must include the criteria used by the board to evaluate the application and the specific reasons for the denial, and these data must be published on the MNsure Web site.

Subd. 5. **Data sharing.** (a) MNsure may share or disseminate data classified as private or nonpublic in subdivision 3 as follows:

(1) to the subject of the data, as provided in section 13.04;

(2) according to a court order;

(3) according to a state or federal law specifically authorizing access to the data;

(4) with other state or federal agencies, only to the extent necessary to verify the identity of, determine the eligibility of, process premiums for, process enrollment of, or investigate fraud related to an individual, employer, or employee participating in MNsure, provided that MNsure must enter into a data-sharing agreement with the agency prior to sharing data under this clause; and

(5) with a nongovernmental person or entity, only to the extent necessary to verify the identity of, determine the eligibility of, process premiums for, process enrollment of, or investigate fraud related to an individual, employer, or employee participating in MNsure, provided that MNsure must enter into a contract with the person or entity, as provided in section 13.05, subdivision 6 or 11, prior to disseminating data under this clause.

(b) MNsure may share or disseminate data classified as private or nonpublic in subdivision 4 as follows:

(1) to the subject of the data, as provided in section 13.04;

(2) according to a court order;

(3) according to a state or federal law specifically authorizing access to the data;

(4) with other state or federal agencies, only to the extent necessary to carry out the functions of MNsure, provided that MNsure must enter into a data-sharing agreement with the agency prior to sharing data under this clause; and

(5) with a nongovernmental person or entity, only to the extent necessary to carry out the functions of MNsure, provided that MNsure must enter a contract with the person or entity, as provided in section 13.05, subdivision 6 or 11, prior to disseminating data under this clause.

(c) Sharing or disseminating data outside of MNsure in a manner not authorized by this subdivision is prohibited. The list of authorized dissemination and sharing contained in this subdivision must be included in the Tennessen warning required by section 13.04, subdivision 2.

(d) Until July 1, 2014, state agencies must share data classified as private or nonpublic on individuals, employees, or employers participating in MNsure with MNsure, only to the extent such data are necessary to verify the identity of, determine the eligibility of, process premiums for, process enrollment of, or investigate fraud related to a MNsure participant. The agency must enter into a data-sharing agreement with MNsure prior to sharing any data under this paragraph.

Subd. 6. **Notice and disclosures.** (a) In addition to the Tennessen warning required by section 13.04, subdivision 2, MNsure must provide any data subject asked to supply private data with:

(1) a notice of rights related to the handling of genetic information, pursuant to section 13.386; and

(2) a notice of the records retention policy of MNsure, detailing the length of time MNsure will retain data on the individual and the manner in which it will be destroyed upon expiration of that time.

(b) All notices required by this subdivision, including the Tennessen warning, must be provided in an electronic format suitable for downloading or printing.

Subd. 7. **Summary data.** In addition to creation and disclosure of summary data derived from private data on individuals, as permitted by section 13.05, subdivision 7, MNsure may create and disclose summary data derived from data classified as nonpublic under this section.

Subd. 8. **Access to data; audit trail.** (a) Only individuals with explicit authorization from the board may enter, update, or access not public data collected, created, or maintained by MNsure. The ability of authorized individuals to enter, update, or access data must be limited through the use of role-based access that corresponds to the official duties or training level of the individual, and the statutory authorization that grants access for that purpose. All queries and responses, and all actions in which data are entered, updated, accessed, or shared or disseminated outside of MNsure, must be recorded in a data audit trail. Data contained in the audit trail are public, to the extent that the data are not otherwise classified by this section.

The board shall immediately and permanently revoke the authorization of any individual determined to have willfully entered, updated, accessed, shared, or disseminated data in violation of this section, or any provision of chapter 13. If an individual is determined to have willfully gained access to data without explicit authorization from the board, the board shall forward the matter to the county attorney for prosecution.

(b) This subdivision shall not limit or affect the authority of the legislative auditor to access data needed to conduct audits, evaluations, or investigations of MNsure or the obligation of the board and MNsure employees to comply with section 3.978, subdivision 2.

(c) This subdivision does not apply to actions taken by a MNsure participant to enter, update, or access data held by MNsure, if the participant is the subject of the data that is entered, updated, or accessed.

Subd. 9. **Sale of data prohibited.** MNsure may not sell any data collected, created, or maintained by MNsure, regardless of its classification, for commercial or any other purposes.

Subd. 10. **Gun and firearm ownership.** MNsure shall not collect information that indicates whether or not an individual owns a gun or has a firearm in the individual's home.

62V.07 FUNDS.

(a) The MNsure account is created in the special revenue fund of the state treasury. All funds received by MNsure shall be deposited in the account. Funds in the account are appropriated to MNsure for the operation of MNsure. Notwithstanding section 11A.20, all investment income and all investment losses attributable to the investment of the MNsure account not currently needed, shall be credited to the MNsure account.

(b) The budget submitted to the legislature under section 16A.11 must include budget information for MNsure.

62V.08 REPORTS.

(a) MNsure shall submit a report to the legislature by January 15, 2015, and each January 15 thereafter, on: (1) the performance of MNsure operations; (2) meeting MNsure responsibilities; (3) an accounting of MNsure budget activities; (4) practices and procedures that have been implemented to ensure compliance with data practices laws, and a description of any violations of data practices laws or procedures; and (5) the effectiveness of the outreach and implementation activities of MNsure in reducing the rate of uninsurance.

(b) MNsure must publish its administrative and operational costs on a Web site to educate consumers on those costs. The information published must include: (1) the amount of premiums and federal premium subsidies collected; (2) the amount and source of revenue received under section 62V.05, subdivision 1, paragraph (b), clause (3); (3) the amount and source of any other fees collected for purposes of supporting operations; and (4) any misuse of funds as identified in accordance with section 3.975. The Web site must be updated at least annually.

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 sunsetting under chapter 3D.

62V.10 RIGHT NOT TO PARTICIPATE.

Nothing in this chapter infringes on the right of a Minnesota citizen not to participate in MNsure.

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. 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.

Subd. 5. **Review of Minnesota eligibility system funding and expenditures.** The committee shall review quarterly reports submitted by the Minnesota Eligibility System Executive Steering Committee under section 62V.055, subdivision 3, regarding Minnesota eligibility system funding and expenditures.

119B.16 FAIR HEARING PROCESS.

Subd. 2. **Informal conference.** The county agency shall offer an informal conference to applicants and recipients adversely affected by an agency action to attempt to resolve the dispute. The county agency shall offer an informal conference to providers to whom the county agency has assigned responsibility for an overpayment in an attempt to resolve the dispute. The county agency or the provider may ask the family in whose case the overpayment arose to participate in the informal conference, but the family may refuse to do so. The county agency shall advise adversely affected applicants, recipients, and providers that a request for a conference with the agency is optional and does not delay or replace the right to a fair hearing.

144.4961 MINNESOTA RADON LICENSING ACT.

Subdivision 1. **Citation.** This section may be cited as the "Minnesota Radon Licensing Act."

Subd. 2. **Definitions.** (a) As used in this section, the following terms have the meanings given them.

(b) "Mitigation" means the act of repairing or altering a building or building design for the purpose in whole or in part of reducing the concentration of radon in the indoor atmosphere.

(c) "Radon" means both the radioactive, gaseous element produced by the disintegration of radium, and the short-lived radionuclides that are decay products of radon.

Subd. 3. **Rulemaking.** The commissioner of health shall adopt rules establishing licensure requirements and work standards relating to indoor radon in dwellings and other buildings, with the exception of newly constructed Minnesota homes according to section 326B.106, subdivision 6. The commissioner shall coordinate, oversee, and implement all state functions in matters concerning the presence, effects, measurement, and mitigation of risks of radon in dwellings and other buildings.

Subd. 4. **System tag.** All radon mitigation systems installed in Minnesota on or after January 1, 2018, must have a radon mitigation system tag provided by the commissioner. A radon mitigation professional must attach the tag to the radon mitigation system in a visible location.

Subd. 5. **License required annually.** Effective January 1, 2018, a license is required annually for every person, firm, or corporation that performs a service for compensation to detect the presence of radon in the indoor atmosphere, performs laboratory analysis, or performs a service to mitigate radon in the indoor atmosphere.

Subd. 6. **Exemptions.** This section does not apply to:

(1) employees of a firm or corporation that installs radon control systems in newly constructed Minnesota homes as specified in subdivision 11;

(2) a person authorized as a building official under Minnesota Rules, part 1300.0070, or that person's designee; or

(3) any person, firm, corporation, or entity that distributes radon testing devices or information for general educational purposes.

Subd. 7. **License applications and other reports.** The professionals, companies, and laboratories listed in subdivision 8 must submit applications for licenses, system tags, and any other reporting required under this section and Minnesota Rules on forms prescribed by the commissioner.

Subd. 8. **Licensing fees.** (a) All radon license applications submitted to the commissioner of health must be accompanied by the required fees. If the commissioner determines that insufficient fees were paid, the necessary additional fees must be paid before the commissioner approves the application. The commissioner shall charge the following fees for each radon license:

(1) Each measurement professional license, $150 per year. "Measurement professional" means any person who performs a test to determine the presence and concentration of radon in a building the person does not own or lease.

(2) Each mitigation professional license, $250 per year. "Mitigation professional" means an individual who installs or designs a radon mitigation system in a building the individual does not own or lease, or provides on-site supervision of radon mitigation and mitigation technicians. "On-site supervision" means a review at the property of mitigation work upon completion of the work and attachment of a system tag. Employees or subcontractors who are supervised by a licensed mitigation professional are not required to be licensed under this clause. This license also permits the licensee to perform the activities of a measurement professional described in clause (1).

(3) Each mitigation company license, $100 per year. "Mitigation company" means any business or government entity that performs or authorizes employees to perform radon mitigation. This fee is waived if the mitigation company employs only one licensed mitigation professional.

(4) Each radon analysis laboratory license, $500 per year. "Radon analysis laboratory" means a business entity or government entity that analyzes passive radon detection devices to determine the presence and concentration of radon in the devices. This fee is waived if the laboratory is a government entity and is only distributing test kits for the general public to use in Minnesota.

(5) Each Minnesota Department of Health radon mitigation system tag, $75 per tag. "Minnesota Department of Health radon mitigation system tag" or "system tag" means a unique identifiable radon system label provided by the commissioner of health.

(b) Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

Subd. 9. **Enforcement.** The commissioner shall enforce this section under the provisions of sections 144.989 to 144.993.

Subd. 10. **Local inspections or permits.** This section does not preclude local units of government from requiring additional permits or inspections for radon control systems, and does not supersede any local inspection or permit requirements.

Subd. 11. **Application; newly constructed homes.** This section does not apply to newly constructed Minnesota homes according to section 326B.106, subdivision 6, prior to the issuance of a certificate of occupancy.

147.0375 MEDICAL FACULTY LICENSE.

Subd. 7. **Expiration.** This section expires July 1, 2018.

148.211 LICENSING.

Subd. 1b. **Advanced practice registered nurse grandfather provision.** (a) The board shall issue a license to an applicant who does not meet the education requirements in subdivision 1a, paragraph (c), clause (3), if the applicant:

(1) is recognized by the board to practice as an advanced practice registered nurse in this state on July 1, 2014;

(2) submits an application to the board in a format prescribed by the board and the applicable fee as determined under section 148.243 by January 1, 2015; and

(3) meets the requirements under subdivision 1a, paragraph (c), clauses (1), (2), (4), (5), and (6).

(b) An advanced practice registered nurse licensed under this subdivision shall maintain all practice privileges provided to licensed advanced practice registered nurses under this chapter.

148.243 FEE AMOUNTS.

Subd. 15. **Practicing without current APRN certification.** The fee for practicing without current APRN certification is $200 for the first month or any part thereof, plus $100 for each subsequent month or part thereof.

148.906 LEVELS OF PRACTICE.

The board may grant licenses for levels of psychological practice to be known as (1) licensed psychologist and (2) licensed psychological practitioner.

148.907 LICENSED PSYCHOLOGIST.

Subd. 5. **Converting from licensed psychological practitioner to licensed psychologist.** Notwithstanding subdivision 3, to convert from licensure as a licensed psychological practitioner to licensure as a licensed psychologist, a licensed psychological practitioner shall have:

(1) completed an application provided by the board for conversion from licensure as a licensed psychological practitioner to licensure as a licensed psychologist;

(2) paid a nonrefundable fee of $500;

(3) documented successful completion of two full years, or the equivalent, of supervised postlicensure employment meeting the requirements of section 148.925, subdivision 5, as it relates to preparation for licensure as a licensed psychologist as follows:

(i) for individuals licensed as licensed psychological practitioners on or before December 31, 2006, the supervised practice must be completed by December 31, 2010; and

(ii) for individuals licensed as licensed psychological practitioners after December 31, 2006, the supervised practice must be completed within four years from the date of licensure; and

(4) no unresolved disciplinary action or complaints pending, or incomplete disciplinary orders or corrective action agreements in Minnesota or any other jurisdiction.

148.908 LICENSED PSYCHOLOGICAL PRACTITIONER.

Subdivision 1. **Scope of practice.** A licensed psychological practitioner shall practice only under supervision that satisfies the requirements of section 148.925 and while employed by either a licensed psychologist or a health care or social service agency which employs or contracts with a supervising licensed psychologist who shares clinical responsibility for the care provided by the licensed psychological practitioner.

Subd. 2. **Requirements for licensure as licensed psychological practitioner.** To become licensed by the board as a licensed psychological practitioner, an applicant shall comply with the following requirements:

(1) have earned a doctoral or master's degree or the equivalent of a master's degree in a doctoral program with a major in psychology from a regionally accredited educational institution meeting the standards the board has established by rule. The degree requirements must be completed by December 31, 2005;

(2) complete an application for admission to the examination for professional practice in psychology and pay the nonrefundable application fee by December 31, 2005;

(3) complete an application for admission to the professional responsibility examination and pay the nonrefundable application fee by December 31, 2005;

(4) pass the examination for professional practice in psychology by December 31, 2006;

(5) pass the professional responsibility examination by December 31, 2006;

(6) complete an application for licensure as a licensed psychological practitioner and pay the nonrefundable application fee by March 1, 2007; and

(7) have attained the age of majority, be of good moral character, and have no unresolved disciplinary action or complaints pending in the state of Minnesota or any other jurisdiction.

Subd. 3. **Termination of licensure.** Effective December 31, 2011, the licensure of all licensed psychological practitioners shall be terminated without further notice and licensure as a licensed psychological practitioner in Minnesota shall be eliminated.

148.909 LICENSURE FOR VOLUNTEER PRACTICE.

Subd. 7. **Continuing education requirements.** A provider licensed under this section is subject to the same continuing education requirements as a licensed psychologist under section 148.911.

148.96 PRESENTATION TO PUBLIC.

Subd. 4. **Persons or techniques not regulated by this board.** (a) Nothing in sections 148.88 to 148.98 shall be construed to limit the occupational pursuits consistent with their training and codes of ethics of professionals such as teachers in recognized public and private schools, members of the clergy, physicians, social workers, school psychologists, alcohol or drug counselors, optometrists, or attorneys. However, in such performance any title used shall be in accordance with section 148.96.

(b) Use of psychological techniques by business and industrial organizations for their own personnel purposes or by employment agencies or state vocational rehabilitation agencies for the evaluation of their own clients prior to recommendation for employment is also specifically allowed. However, no representative of an industrial or business firm or corporation may sell, offer, or provide any psychological services as specified in section 148.89 unless such services are performed or supervised by individuals licensed under sections 148.88 to 148.98.

Subd. 5. **Other professions not authorized.** Nothing in sections 148.88 to 148.98 shall be construed to authorize a person licensed under sections 148.88 to 148.98 to engage in the practice of any profession regulated under Minnesota law unless the person is duly licensed or registered in that profession.

179A.50 REPRESENTATION OF FAMILY CHILD CARE PROVIDERS.

Sections 179A.50 to 179A.52 shall be known as the Family Child Care Providers Representation Act.

179A.51 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of sections 179A.50 to 179A.52, the terms in this section have the meanings given them.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of mediation services.

Subd. 3. **Exclusive representative.** "Exclusive representative" means an employee organization that has been elected and certified under section 179A.52, thereby maintaining the right to represent family child care providers in their relations with the state.

Subd. 4. **Family child care provider.** "Family child care provider" means an individual, either licensed or unlicensed, who provides legal child care services as defined under section 245A.03, except for providers licensed under Minnesota Rules, chapter 9503, or excluded from licensure under section 245A.03, subdivision 2, paragraph (a), clause (5), and who receives child care assistance to subsidize child care services for a child or children currently in the individual's care, under sections 119B.03; 119B.05; and 119B.011, subdivisions 20 and 20a.

179A.52 RIGHT TO ORGANIZE.

Subdivision 1. **Rights of individual providers and participants.** For the purposes of the Public Employment Labor Relations Act, under chapter 179A, family child care providers shall be considered, by virtue of this section, executive branch state employees employed by the commissioner of management and budget or the commissioner's representative. This section does not require the treatment of family child care providers as public employees for any other purpose. Family child care providers are not state employees for purposes of section 3.736. Chapter 179A shall apply to family child care providers except as otherwise provided in this section. Notwithstanding section 179A.03, subdivision 14, paragraph (a), clause (5), chapter 179A shall apply to family child care providers regardless of part-time or full-time employment status. Family child care providers shall not have the right to strike.

Subd. 2. **Appropriate unit.** The only appropriate unit under this section shall be a statewide unit of all family child care providers who meet the definition in section 179A.51, and who have

had an active registration under chapter 119B within the previous 12 months. The unit shall be treated as an appropriate unit under section 179A.10, subdivision 2.

Subd. 3. **Compilation of list.** The commissioner of human services shall, by July 1, 2013, and monthly thereafter, compile and maintain a list of the names and addresses of all family child care providers who meet the definition in section 179A.51, and who have had an active registration under chapter 119B within the previous 12 months. The list shall not include the name of any participant, or indicate that an individual provider is a relative of a participant or has the same address as a participant. The commissioner of human services shall share the lists with others as needed for the state to meet its obligations under chapter 179A as modified and made applicable to family child care providers under this section, and to facilitate the representational processes under this section.

Subd. 4. **List access.** Beginning July 1, 2013, upon a showing made to the commissioner of the Bureau of Mediation Services by any employee organization wishing to represent the appropriate unit of family child care providers that at least 500 family child care providers support such representation, the commissioner of human services shall provide to such organization within seven days the most recent list of actively registered family child care providers compiled under subdivision 3, and subsequent monthly lists upon request for an additional three months. When the list is made available to an employee organization under this subdivision, the list must be made publicly available.

Subd. 5. **Elections for exclusive representative.** After July 31, 2013, any employee organization wishing to represent the appropriate unit of family child care providers may seek exclusive representative status pursuant to section 179A.12. Certification elections for family child care providers shall be conducted by mail ballot, and such election shall be conducted upon an appropriate petition stating that at least 30 percent of the appropriate unit wishes to be represented by the petitioner. The family child care providers eligible to vote in any such election shall be those family child care providers on the monthly list of family child care providers compiled under this section, most recently preceding the filing of the election petition. Except as otherwise provided, elections under this subdivision shall be conducted in accordance with section 179A.12.

Subd. 6. **Meet and negotiate.** If the commissioner certifies an employee organization as the majority exclusive representative, the state, through the governor or the governor's designee, shall meet and negotiate in good faith with the exclusive representative of the family child care provider unit regarding grievance issues, child care assistance reimbursement rates under chapter 119B, and terms and conditions of service, but this obligation does not compel the state or its representatives to agree to a proposal or require the making of a concession. The governor or the governor's designee is authorized to enter into agreements with the exclusive representative. Negotiated agreements and arbitration decisions must be submitted to the legislature to be accepted or rejected in accordance with sections 3.855 and 179A.22.

Subd. 7. **Meet and confer.** The state has an obligation to meet and confer under chapter 179A with family child care providers to discuss policies and other matters relating to their service that are not terms and conditions of service.

Subd. 8. **Terms and conditions of service.** For purposes of this section, "terms and conditions of service" has the same meaning as given in section 179A.03, subdivision 19.

Subd. 9. **Rights.** Nothing in this section shall be construed to interfere with:

(1) parental rights to select and deselect family child care providers or the ability of family child care providers to establish the rates they charge to parents;

(2) the right or obligation of any state agency to communicate or meet with any citizen or organization concerning family child care legislation, regulation, or policy; or

(3) the rights and responsibilities of family child care providers under federal law.

Subd. 10. **Membership status and eligibility for subsidies.** Membership status in an employee organization shall not affect the eligibility of a family child care provider to receive payments under, or serve a child who receives payments under, chapter 119B.

179A.53 NO USE OF SCHOLARSHIPS FOR DUES OR FEES.

Early learning scholarships shall not be applied, through state withholding or otherwise, toward payment of dues or fees that are paid to exclusive representatives of family child care providers.

245E.03 DUTY TO PROVIDE ACCESS.

Subd. 3. **Notice of denial or termination.** When a provider fails to provide access, a 15-day notice of denial or termination must be issued to the provider, which prohibits the provider

from participating in the child care assistance program. Notice must be sent to recipients whose children are under the provider's care pursuant to Minnesota Rules, part 3400.0185.

245E.06 ADMINISTRATIVE SANCTIONS.

Subd. 4. **Consolidated hearings with licensing sanction.** If a financial misconduct sanction has an appeal hearing right and it is timely appealed, and a licensing sanction exists for which there is an appeal hearing right and the sanction is timely appealed, and the overpayment recovery action and licensing sanction involve the same set of facts, the overpayment recovery action and licensing sanction must be consolidated in the contested case hearing related to the licensing sanction.

Subd. 5. **Effect of department's administrative determination or sanction.** Unless a timely and proper appeal is received by the department, the department's administrative determination or sanction shall be considered a final department determination.

256B.4914 HOME AND COMMUNITY-BASED SERVICES WAIVERS; RATE SETTING.

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

(1) for residential services: 1.003;

(2) for day services: 1.000;

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

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

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

256B.7631 CHEMICAL DEPENDENCY PROVIDER RATE INCREASE.

For the chemical dependency services listed in section 254B.05, subdivision 5, and provided on or after July 1, 2015, payment rates shall be increased by two percent over the rates in effect on January 1, 2014, for vendors who meet the requirements of section 254B.05.

256C.23 DEFINITIONS.

Subd. 3. **Regional service center.** "Regional service center" means a facility designed to provide an entry point for deaf, deafblind, and hard-of-hearing persons of that region in need of education, employment, social, human, or other services.

256C.233 DUTIES OF STATE AGENCIES.

Subd. 4. **State commissioners.** The commissioners of all state agencies shall consult with the Deaf and Hard-of-Hearing Services Division concerning the promulgation of public policies, regulations, and programs necessary to address the needs of deaf, deafblind, and hard-of-hearing Minnesotans. Each state agency shall consult with the Deaf and Hard-of-Hearing Services Division concerning the need to forward legislative initiatives to the governor to address the concerns of deaf, deafblind, and hard-of-hearing Minnesotans.

256C.25 INTERPRETER SERVICES.

APPENDIX
Repealed Minnesota Statutes: UES0800-1

Subdivision 1. **Establishment.** The Deaf and Hard-of-Hearing Services Division shall maintain and coordinate statewide interpreting or interpreter referral services for use by any public or private agency or individual in the state. The division shall directly coordinate these services but may contract with an appropriate agency to provide this service. The division may collect a $3 fee per referral for interpreter referral services and the actual costs of interpreter services provided by department staff. Fees and payments collected shall be deposited in the general fund. The $3 referral fee shall not be collected from state agencies or local units of government or deaf or hard-of-hearing consumers or interpreters.

Subd. 2. **Duties.** Interpreting or interpreter referral services must include:

(1) statewide access to interpreter referral and direct interpreting services, coordinated with the regional service centers;

(2) maintenance of a statewide directory of qualified interpreters;

(3) assessment of the present and projected supply and demand for interpreter services statewide; and

(4) coordination with the regional service centers on projects to train interpreters and advocate for and evaluate interpreter services.

3400.0185 TERMINATION AND ADVERSE ACTIONS; NOTICE REQUIRED.

Subp. 5. **Notice to providers of actions adverse to the provider.** The county must give a provider written notice of the following actions adverse to the provider: a denial of authorization, a termination of authorization, a reduction in the number of hours of care with that provider, and a determination that the provider has an overpayment. The notice must include the following information:

A. a description of the adverse action;

B. the effective date of the adverse action; and

C. a statement that unless a family appeals the adverse action before the effective date or the provider appeals the overpayment determination, the adverse action will occur on the effective date. The notice must be mailed to the provider at least 15 calendar days before the effective date of the adverse action.